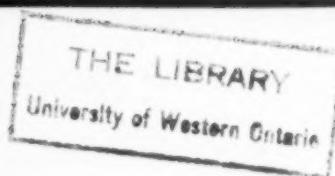


(D)
March, 1958

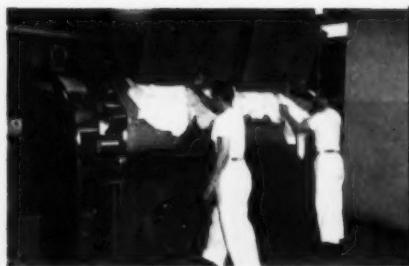
Canadian Hospital



- *A symposium on controlling staphylococcus*
- *L'accréditation des hôpitaux*
- *Operating budgets in Ontario*
- *Emotions and the diet*



Canadian Hospital Association



Loading Chutes, directly from soiled linen room at St. Michael's Hospital, quickly fill each of four Cascade Unloading Washers to exact capacity with no manual handling of work.



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Automatic Folding of large flatwork by Pneumatic Folder at delivery end of Super-Sylex Ironers (foreground) enables only one receiving operator to handle entire output of Ironer. Small flatwork is ironed on Streamline Ironer at left.



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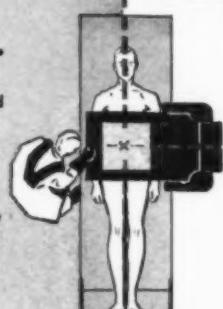
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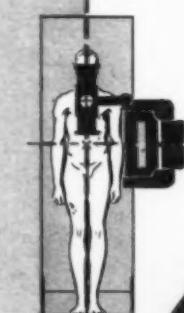
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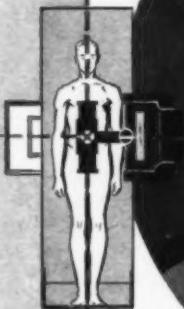
- 1 Move the Serialfilmer toward the table centerline: it will lock automatically when the screen center arrives at Bucky center. While observing fluoroscopically, shift patient to locate area of interest at screen center (easy to do by shifting down). Park the screen.



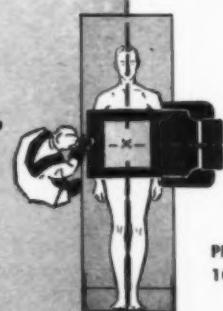
- 2 Bring overhead x-ray tube above patient; it locks automatically at centerline. Press a button on a pendant switch and the tube automatically lowers to correct target-film distance. No measuring to do, no scales to consult... you can do it without even looking.



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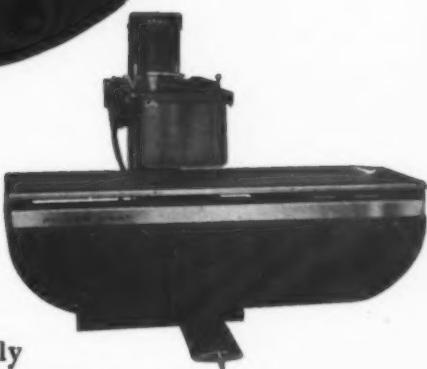
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Canadian Hospital

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MARCH, 1958

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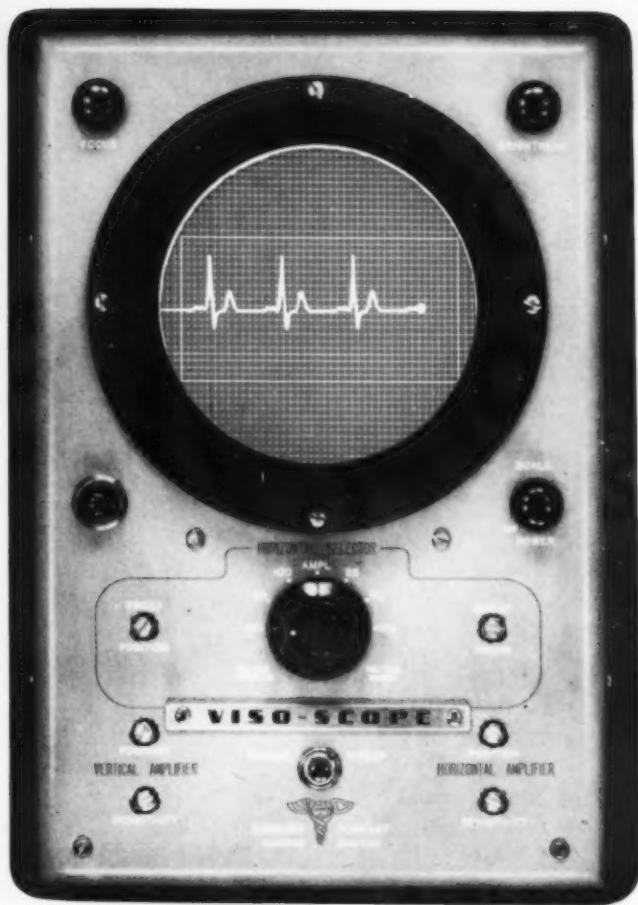
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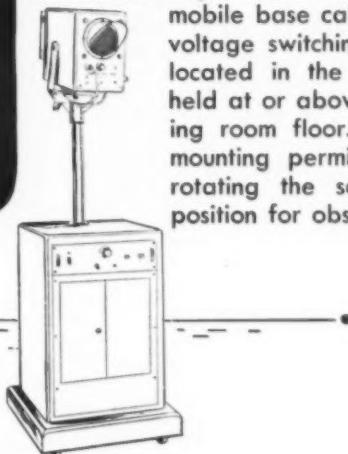
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The continually growing demand for Farmer's Wife has resulted in a further expansion of production facilities in the Atlantic Provinces.

For almost a year, Central Creameries Limited of Charlottetown, has been manufacturing Farmer's Wife at Charlottetown under the direction of Cow & Gate technicians to Farmer's Wife high quality specifications. Both companies have found this so advantageous that an arrangement has been entered into by which Cow & Gate (Canada) Limited will have a half interest in Central Creameries Limited.

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◀ Notes About People ▶

From Pharmacy in Ireland

Stanley J. Johnston has been appointed administrator of Leamington District Memorial Hospital, Leamington, Ontario, effective March 1. A native of Ireland, Mr. Johnston, was employed as pharmacist at St. Bartholemew's Hospital, London, England, prior to war service in the Royal Air Force. Since coming to Canada he has been chief pharmacist and, later, assistant superintendent of Metropolitan General Hospital, Windsor, Ontario; and for the past five years he has been business manager of Essex County Sanatorium in Windsor. In 1955, Mr. Johnston successfully completed the extension course in hospital organization and management, which is conducted by the Canadian Hospital Association.

Appointments at Yorkton-Melville Health Region

Dr. P. T. Prestage has been named medical health officer in charge of the new Yorkton-Melville health region in Saskatchewan. Vera Spencer will take over the duties of senior public health nurse and N. Basarsky will be senior sanitary officer.

Father Bertrand Resigns Presidency



The Rev. Hector L. Bertrand, s.j., has resigned as president of the Comité des Hôpitaux du Québec, a position he has held for ten

years. During this time Father Bertrand has done much to build up the "Comité", has established the journal, *L'Hôpital d'aujourd'hui*, and the Ecole d'Administration Hospitalière. He still remains with the organization as director.

Father Bertrand is succeeded as president by Dr. Eugène Thibault, who is medical director of Hôpital Général de Verdun, Verdun, Que., and chairman of the Canadian Commission on Hospital Accreditation.

Frederick W. Jackson

Frederick Wilbur Jackson, M.D., died on January 10 in Winnipeg, Manitoba, at the age of 69.

A native of Stonewall, Man., Dr. Jackson graduated in medicine from the University of Manitoba in 1912, and received a Diploma of Public Health from the University of Toronto in 1929.

After serving for 17 years as Deputy Minister of Health and Public Welfare for the province of Manitoba, he was appointed director of health insurance studies in the Department of National Health and Welfare in August, 1948. A few years later he became director of Health Services of that department. His administration of the national health program in extending hospital, diagnostic and public health services throughout Canada has been recognized as a major contribution to Canadian health services. He also represented Canada at the fifth meeting of the interim commission of the World Health Organization in Geneva in 1948, and studied for some time the United Kingdom's health insurance and social security plans.

Dr. Jackson was the recipient of the King George V Silver Jubilee Medal, the King George VI Coronation Medal for Meritorious Civil Service, as well as the Medal of the Professional Institute of the Civil Service of Canada.

His outstanding achievements in the fields of medical care and public health in Canada will long be remembered.

G. L. Pickering in New Post

Gordon L. Pickering has been appointed Commissioner of Hospitalization for Manitoba. The creation of this new post was made necessary by the decision of the Government of Manitoba to have a hospital insurance plan in operation before January 1, 1959.

Mr. Pickering started his career in hospital administration as an



Gordon L. Pickering

accountant with the Grey Nuns' Hospital in Regina, Sask., in 1937. He served with the R.C.A.F. during the war and then as accountant with the Holy Cross Hospital, Calgary, Alta. In 1949 he became associated with the St. Boniface Hospital where he served as accountant, comptroller and business administrator. He is director of the Canadian Hospital Association, past-president of the Associated Hospitals of Manitoba, and has been closely associated with Blue Cross in Manitoba for a number of years. He is a member of the Manitoba Hospital Rate Board and the Health Advisory Commission, and holds degrees from the University of Manitoba, and from the University of Saskatchewan. He is also a graduate of the C.H.A. extension course in hospital organization and management.

Gordon Pickering brings to his new post a wide background in hospital administration, a broad acquaintance with hospital people throughout Canada and a keen appreciation of hospital problems. His many friends will wish him every success in his new work.

(concluded on page 18)

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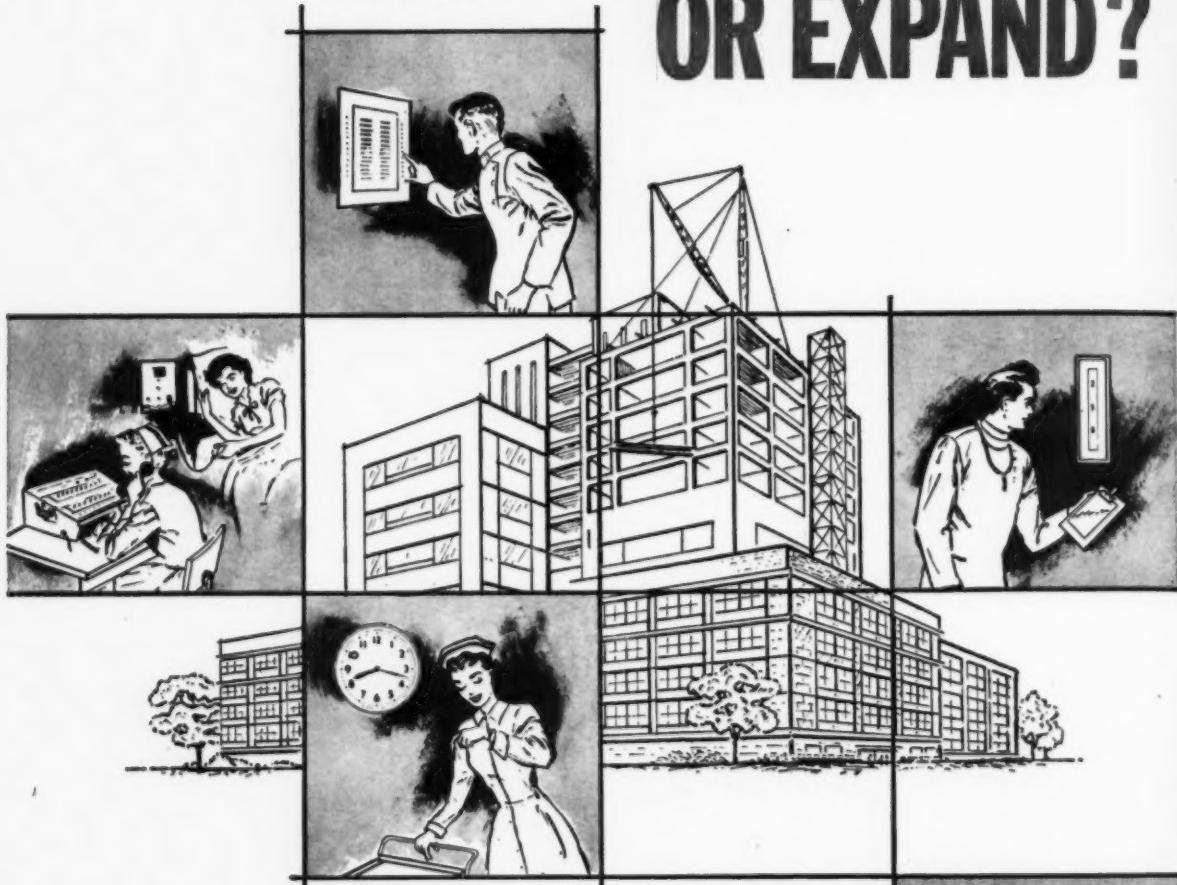
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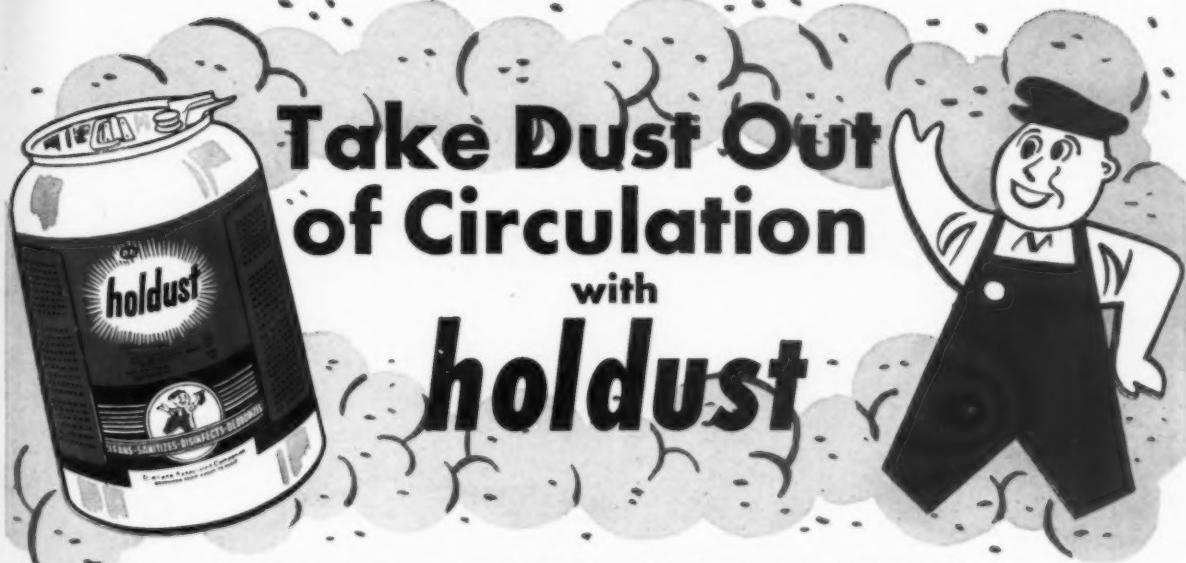
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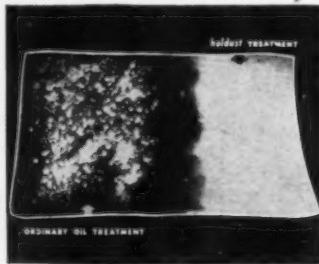
The CANADIAN HOSPITAL



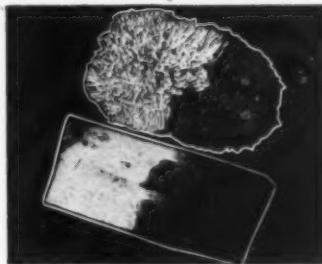
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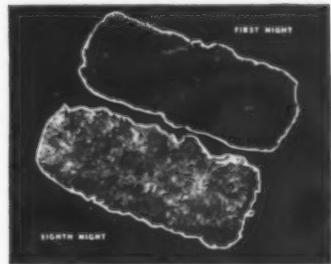
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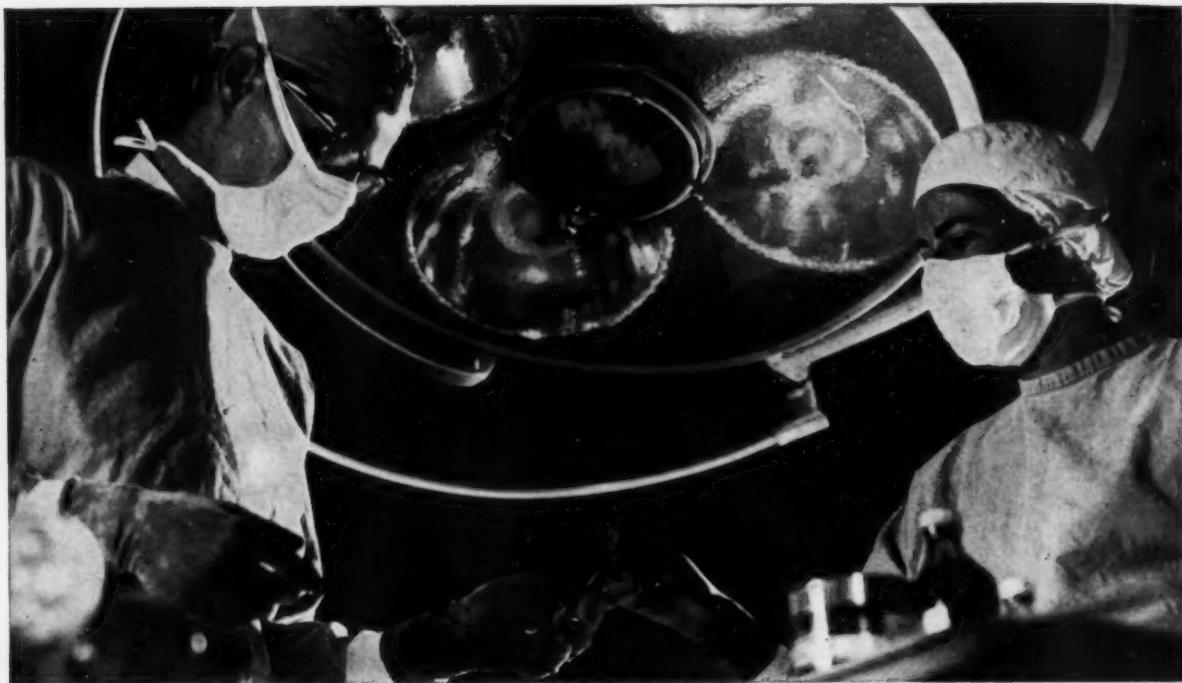
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Clay-Adams
NEW YORK 10

People
(concluded from page 12)

At St. Joseph's, Toronto

A graduate of the school of nursing at St. Joseph's Hospital in Toronto, Sister Mary Fintan has been appointed assistant superintendent of that hospital. Sister Mary also graduated in Arts at the University of Toronto and in 1955 completed the diploma course in hospital administration at the same university. In her new post, she succeeds Sister Amata who has been appointed assistant superior at the House of Providence, a home for the aged in Toronto.

The latter institution has opened a campaign for funds to assist in the construction of a long-needed new House and Sister Amata's years of experience during the construction program at St. Joseph's will be highly valuable to the House of Providence.

**Superintendent at
Ste Anne de Bellevue**

The appointment of Maurice Thibault, M.D., as superintendent of Ste Anne's Hospital at Ste Anne de Bellevue, Que., has been announced.

A native of Sherbrooke, Que., Dr. Thibault is a graduate of the University of Montreal. In 1955 he was appointed assistant superintendent of Queen Mary Veterans' Hospital, Montreal, Que., where he has been until his recent appointment at Ste Anne's.

Officers of the M.H.S.A.

At a February meeting of the Maritime Hospital Services Association (Blue Cross) the by-laws of the association were amended to permit changes in the positions of executive officers. The slate now reads as follows: *President*, Dr. J. A. MacDougall, Saint John, N.B. (appointed by the Board); *vice-president and medical director*, Dr. J. A. McMillan, Charlottetown, P.E.I.; *vice-president in charge of enrolment and secretary of the Board*, T. Ledwell Doyle; *vice-president, controller, and treasurer of the Board*, Donald O. Downing; *executive consultant*, Ruth Cook Wilson; *chairman of the Board*, John N. Flood, Saint John, N.B.

New Superintendent at Clinton

Hilda Smith has been appointed as superintendent of the Clinton Public Hospital, Clinton, Ont., suc-

ceeding Annette Sinclair who resigned in January. Miss Smith, a native of Winnipeg, Man., served as superintendent for five years at the Alexandra Marine and General Hospital in Goderich, Ont. She is a graduate of the Margaret Eaton School of Health and Physical Education and trained at the Hamilton General Hospitals, Hamilton, Ont.

- Dr. Kenneth Murray has resigned as active chief of surgery of St. Joseph's Hospital, Hamilton, Ont. He is succeeded by Dr. Alan G. Lane, who has been an active member of the surgical staff of St. Joseph's for nine years.

- M. G. Graves of Calgary, Alta., has been appointed as president of the newly-formed Alberta Crippled Children's Hospital Society, Calgary, Alta.

- Dr. Harold V. Waldon, superintendent of the Cruise Memorial Hospital, Vita, Man., has resigned from his post after 30 years of service.

- Dr. I. Gogan, medical director of Holy Cross Hospital, Calgary, Alta., has been appointed executive director of the Catholic Hospital Conference of Alberta.

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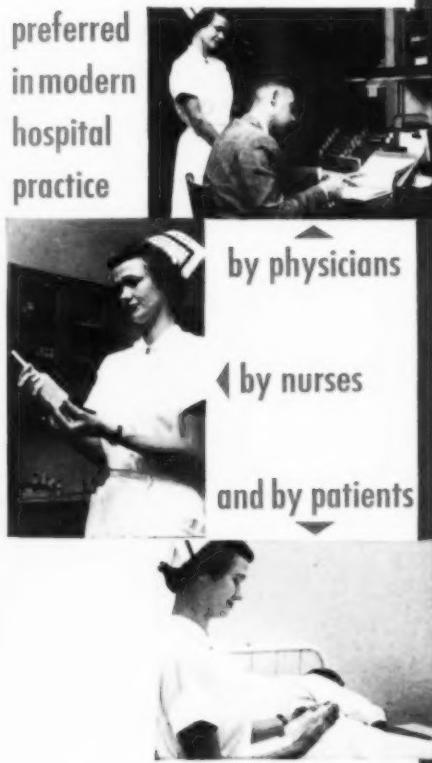
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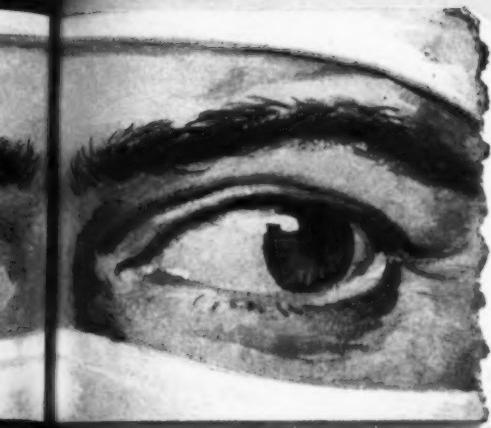
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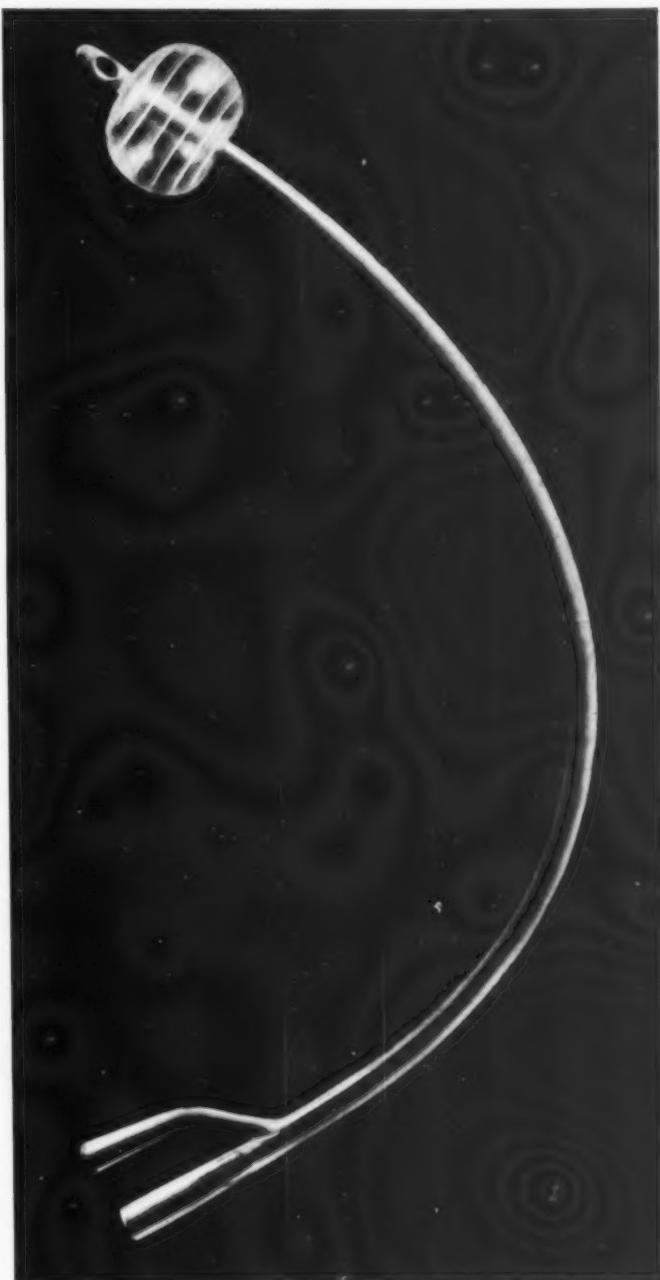
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The Extension Course for
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Enrol Now for 1958

A few more students can be accepted for the 1958 class in the extension course for medical record librarians—but applications must be received by March 31st. The course will commence in late August. This will be the sixth group of students to undertake the training sponsored by the Canadian Association of Medical Record Librarians and the Canadian Hospital Association. Persons with junior matriculation, or the equivalent, who are already employed in the medical record department of a hospital or clinic are eligible for enrollment. Either one or two years may be taken. A certificate of accomplishment is awarded by the Canadian Association of Medical Record Librarians upon the successful completion of each year. A home-study or winter session of eight months is followed each year by a 4-week intramural summer session in a Canadian hospital approved for the purpose.

Information and application forms may be obtained from: The Secretary, Committee on Education, Canadian Hospital Association, 280 Bloor Street West, Toronto 5, Ontario.

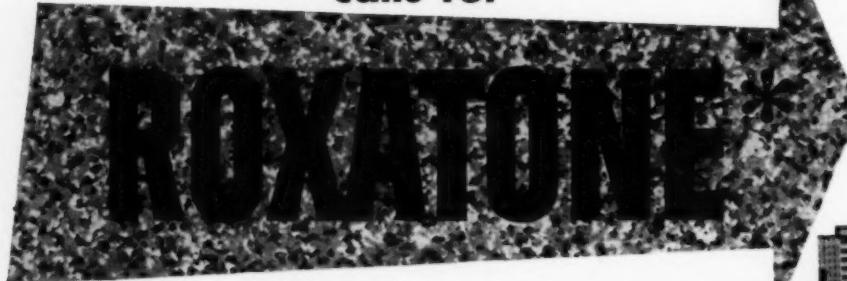
Closed Circuit TV For Cancer Research

An ultra-violet television microscope was demonstrated for the first time in the United Kingdom at the Northern Polytechnic, London. An industrial camera projects the microscope image onto a screen.

It was pointed out at this demonstration that the difference between an ordinary ultra-violet microscope and one using television lies in the amount of ultra-violet radiation required to obtain an image. The intensity of radiation required by the usual ultra-violet microscope tends to kill the specimen. It has required considerable technical research to produce an instrument which does not damage the living tissue to be examined in cancer research. The new television microscope also avoids delays for development of photographs, since it projects the image of the specimen immediately.

This use of television may prove to be of great help in cancer research and in general research education.—United Kingdom Information Service.

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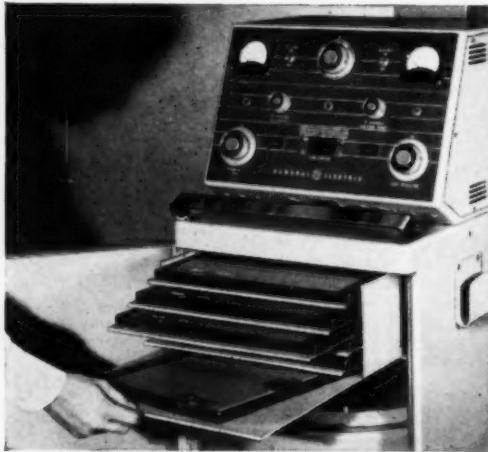
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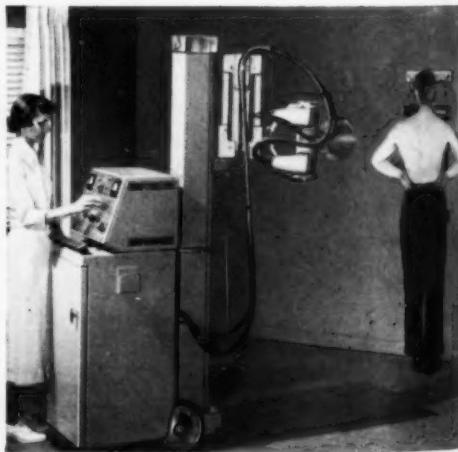
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The two-year program is now in its seventh year, and the certificate of graduation given by the Canadian Hospital Association has been granted to 250 persons. Those enrolled in the course spend eight months each year studying lessons at home and preparing assignments. This period is followed by an examination and a four-week intramural summer session at a specified Canadian university.

Information and application forms may be obtained by writing to: The Secretary, Committee on Education, Canadian Hospital Association, 280 Bloor Street West, Toronto 5, Ontario.

Hospital Housekeeping Course
A housekeeping course especially for hospital personnel will be held again for the tenth consecutive year, from March 31-May 23, at Michigan State University, East Lansing, Michigan.

The course, sponsored by the American Hospital Association in co-operation with the Michigan State University, is set to provide practical training in up-to-date hospital housekeeping procedures for executive housekeepers, members of hospital housekeeping staffs and prospective employees.

Registration blanks can be obtained from the American Hospital Association and should be sent to the Short Course in Hospital Housekeeping, Kellogg Centre for Continuing Education, Michigan State University, East Lansing, Mich., U.S.A.

Subjects covered will include the philosophy of hospital care and institutional organization, personnel management, institutional management, and housekeeping supplies, equipment and procedure.

A child's education should begin at least one hundred years before he is born.—*Oliver Wendell Holmes*

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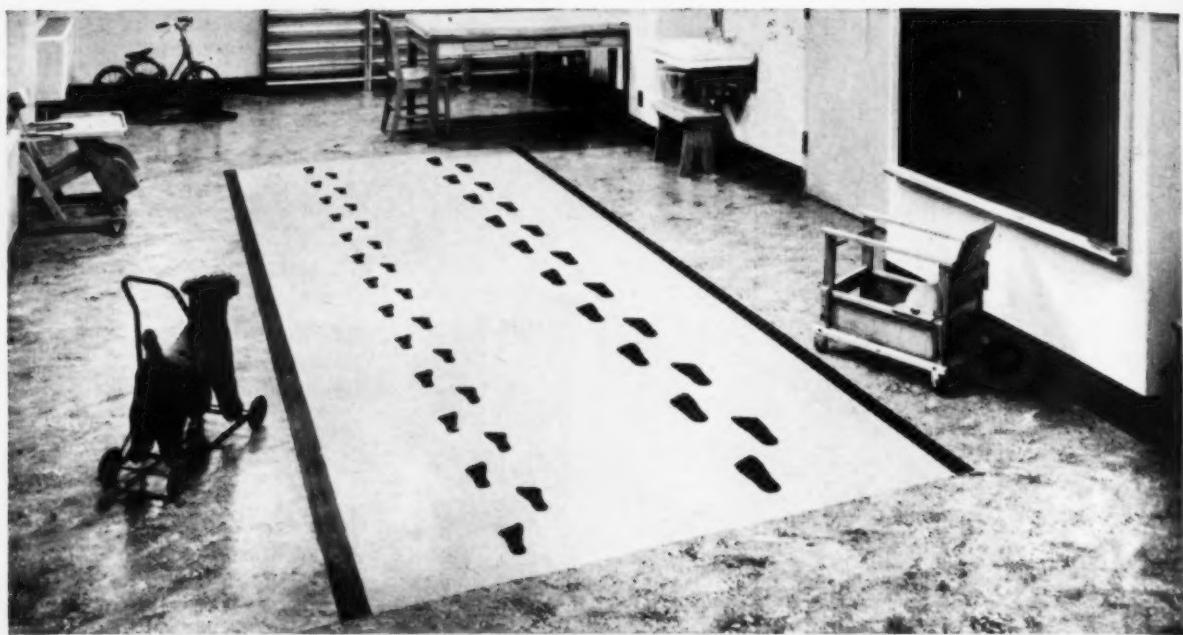
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SOMETIMES we wonder if people really mean what they say. Again and again, during the past few years we have heard complaints about the shortage of medical record librarians. Whether the hospital is large or small, it is the same story all across Canada. Yet, though educational facilities for training in medical record work have been increased, both in hospital schools and by the extension course offered jointly by the Canadian Association of Medical Record Librarians and the Canadian Hospital Association, there has been little increase in the number of people adequately trained in this important field. Even when offered the facilities for training additional staff, the people most directly concerned are slow to act.

Nor is the administrator's job finished when he has a well-trained department head. To achieve smooth, efficient departmental operation he should be planning for other individuals in the department to be given additional training. Not only will education in the lower echelons of the staff prepare against the time when the department head is no longer associated with that particular hospital and forestall a breakdown of services in an emergency, but when more people know what should be going on in the department less time will be spent in trial—and error.

It is through positive, planned action by administrators that efficient and effective staffing of hospital departments will become a reality. Wishful thinking will not do it. Are administrators just going to complain about the lack of trained medical record librarians? You may have one person trained now, but are you bringing along the other people in that department?

Our extension course is readily available no matter where you are. The closing date for acceptance is March 31. There are still a few vacancies. Are you going to do anything about it?

Federal Construction Grants Raised

ON January 25, 1958, the Minister of National Health and Welfare announced in the House of Commons a new schedule of federal hospital construction grants effective on January 1. Assistance in the provision of beds for the acutely and chronically ill is increased from \$1,000 and \$1,500 respectively to \$2,000 per bed. Assistance for the construction of nurses' residences has been augmented from \$500 to

\$750 per bed; interns' quarters in hospitals have received the same consideration. Assistance towards the construction of bed-equivalents, such as every three newborn nursery bassinets, and every 300 square feet of floor area devoted to community health services, whether constructed as part of a hospital or not, is increased from \$1,000 to \$2,000 per bed-equivalent. As a new departure, major renovations and alterations to existing hospital beds or bed-equivalent facilities will be considered for assistance within the terms of the grant. These changes were announced on page 62 of our February issue.

In his statement to the House, Mr. Monteith noted that the program of construction grants was originally established, in 1948, on a five-year basis to provide financial assistance for the alleviation of the immediate bed shortage. This was estimated at that time as approximately 40,000 beds. As the number of beds constructed during the first five-year period exceeded the originally estimated shortage, the construction grant was reduced to one-half the original amount, from about \$13 million a year to \$6.5 million a year. Experience proved that the reduced amount was insufficient to take care of construction desired during the second five-year period. Therefore it was announced that hospital construction grants would be extended after March 31, 1958, for a further period of five years.

The following three paragraphs, taken from *Hansard*, Vol. 101, No. 72, will be of wide interest.

"The unprecedented growth in population, the changing pattern and utilization of hospitals—due in part to the extension of hospitalization prepayment plans—the steady increase in the costs of hospital construction, the increased emphasis given to planning at all levels for the construction of necessary additional hospital facilities in Canada by the passing of the Hospital Insurance and Diagnostic Services Act, and the urging of the Canadian Hospital Association and of others, have led this government to consider an immediate revision of the terms and conditions of the hospital construction grant.

"In order to reassure the provinces, municipalities, local hospital boards and organizations responsible for the long-term planning and carrying out of the construction of necessary and adequate hospital facilities, which in most cases require at least two to five years to complete for each hospital, it will be government policy to continue this grant on at least the above terms for the next five fiscal years, beginning

April 1, 1958. It is also our intention to add a final supplementary estimate dealing with the hospital construction grant for the fiscal year 1957-58 in order to meet any additional claims on behalf of the cost of construction of hospitals during the period January 1, 1958 to March 31, 1958.

"It is hoped that this enlargement of federal assistance to the provinces towards the capital costs of the construction of hospital facilities within the terms of the hospital construction grant will have a salutary effect not only on the stimulation and construction of necessary, well-planned hospital facilities but also on the early implementation of agreements with the provinces under the Hospital Insurance and Diagnostic Services Act. Moreover, the government feels that making these additional funds available now will prove of value in stimulating new construction which can be expected to help alleviate unemployment which may exist in localities where this type of construction should be undertaken."

The urging from the Canadian Hospital Association, referred to by the Minister, took the form of a brief which officers of this association presented to him on September of 1957 (see Canadian Hospital, November 1957, page 35). This brief asked for these considerations:

That the hospital construction grants be continued for a further period of five years from April 1, 1958.

That the scope of the grants be broadened in order that a construction project involving any hospital department or hospital residence accommodation may become eligible for grant assistance.

That the formulae upon which the grants are calculated be modified, and the amounts provided be increased so that the contribution by the Government of Canada to each hospital construction project shall equal approximately one-third of the total cost.

The brief was based on resolutions passed at the biennial meeting of the Canadian Hospital Association in May 1957, and on resolutions endorsed by member associations and Catholic conferences at their annual meetings. Although the increased basis of the grants is lower than requested in our brief, it should be noted that the new schedule restores the relative value of the grants to their 1948 standard, taking into account the rise in construction costs which has occurred since then. It should also be noted that the government will continue the grants on the announced terms at least, for the next five fiscal years. This can mean that there is every possibility that they will be reviewed during that period.

Since the new grant for major renovations and alterations got only a brief mention, it will be necessary to wait until the order-in-council on this grant is made public before the scope of its application can be ascertained.

The new basis of the federal construction grants should assist particularly those hospitals where construction has been planned, but deferred because of insufficient funds. Undoubtedly, in many instances, these grants will mean an early start on projects which are essential now.

Subventions Fédérales à la Construction

LE 25 janvier 1958, Le Ministre de la Santé Nationale et du Bien-Etre Social a fait part à la Chambre des Communes d'un nouveau barème de subventions fédérales à la construction hospitalière, applicable à compter du 1er janvier. En ce qui concerne les constructions destinées à fournir des lits de malades

aigus et de malades chroniques, l'aide, qui s'élevait respectivement à \$1,000 et \$1,500 par lit, est portée à \$2,000. L'aide à la construction de logements d'infirmières est passée de \$500 à \$750 par lit; les locaux affectés aux internes des hôpitaux ont bénéficié d'une mesure identique. En ce qui concerne la construction de locaux équivalant à des unités-lit, à raison pour un lit de trois berceaux de nurserie pour nouveau-nés par exemple, ou encore d'une surface de plancher de 300 pieds carrés affectés aux services sanitaires de la collectivité, l'aide est portée de \$1,000 à \$2,000 par unité équivalant à un lit, qu'il s'agisse de constructions hospitalières ou non. Perspective nouvelle; les rénovations et modifications importantes d'aménagements comprenant des unités-lit ou des unités équivalentes seront prises en considération en vue de l'attribution d'une aide dans la mesure où elles satisferont aux conditions d'attribution de la subvention. Ces changements ont été annoncés à la page 62 de notre numéro de février.

Dans son rapport à la Chambre, M. Monteith notait que le programme des subventions à la construction fut d'abord établi, en 1948, sur une base de cinq ans pour aider financièrement à soulager l'urgent besoin de lits. On estimait à l'époque qu'il manquait 40,000 lits. Comme le nombre d'unités-lit construites au cours de cette première période de cinq ans excéda cette première estimation des besoins en lits, la subvention à la construction fut réduite à la moitié du montant primitif, soit d'environ 13 millions de dollars par an à 6 millions et demi de dollars par an. L'expérience a prouvé que le montant réduit était insuffisant pour maintenir la construction au niveau désiré pendant la seconde période de cinq ans. En conséquence il fut annoncé que les subventions à la construction hospitalière seraient prorogées, après le 31 mars 1958, pour une période supplémentaire de cinq ans.

Les trois paragraphes suivants, parus à l'époque dans Hansard, volume 101, No 72, présentent un grand intérêt:

"L'augmentation sans précédent de la population, l'évolution des hôpitaux et de leur rôle—évolution due en partie à l'extension des plans d'assurance hospitalisation—l'accroissement constant des coûts de la construction hospitalière, la considération accrue accordée à la planification à tous les niveaux pour la construction de nouvelles facilités hospitalières nécessaires au Canada, considération motivée par le vote de la Loi sur L'Assurance Hospitalisation et les Services de Diagnostic ainsi que par les instances de l'Association des Hôpitaux du Canada et d'autres organisations, sont les raisons qui ont amené ce gouvernement à envisager une révision immédiate des clauses et conditions d'attribution de la subvention à la construction hospitalière.

"Afin de rassurer les provinces, les municipalités, les organisations et conseils locaux d'hôpitaux chargés d'élaborer et d'exécuter les projets de longue haleine que représente la construction des aménagements hospitaliers nécessaires et adéquats, tâche dont l'accomplissement prend, dans la plupart des cas, de deux à cinq ans au moins pour chaque hôpital, le gouvernement continuera d'accorder cette subvention sur une base au moins égale à celle indiquée plus haut pendant les cinq prochaines années fiscales à compter du 1er avril 1958. Nous avons également l'intention d'ajouter un dernier crédit supplémentaire à la subvention à la construction hospitalière accordée pour l'année fiscale 1957-58 afin de satisfaire à toute

(suite à la page 88)



Controlling Staphylococcus

Hospital organization

A. L. Swanson, M.D.*

THE organism *Micrococcus Pyogenes* Var. *Aureus*, commonly called Staphylococcus Pyogenes or the Golden Staph, is one of the oldest and most commonly known to man. Its effects have been mentioned in the Bible (Exodus 9: 9-11, Job 2: 7)¹ and have been observed in Egyptian mummies. "Laudable pus" was a popular medical term in bygone eras and man has been treated for boils, abscesses and other infections caused by the staphylococcus at least since the recording of medical data was begun.

*Dr. Swanson is Executive Director of University Hospital, Saskatoon, Saskatchewan. This article and those which follow in this series are from addresses delivered at the meeting of the Saskatchewan College of Physicians and Surgeons, October, 1957.

**For references see page 42.

The incidence and severity of staphylococcal and other infections has been reduced progressively by such measures as cleanliness, antisepsis, asepsis, improved operative technique, sulpha drugs and, lastly, the antibiotics. However, during the past ten years there has been an increasing number of reports of staphylococcal infections in hospitalized patients.² Despite continuing progress in nearly every area of medical care, serious infections caused by staphylococcal organisms appear to have been increasing, particularly in the past three to four years. The "wonder" drugs are often ineffective against the staphylococcus and frequently, by eliminating competing organisms, appear to enhance the growth and virility of the staphylococcus.

Because the organism is so widespread in our population—not only as a pathogen but also as a normal inhabitant of the nasopharynx in

Continuing Committee on Infections

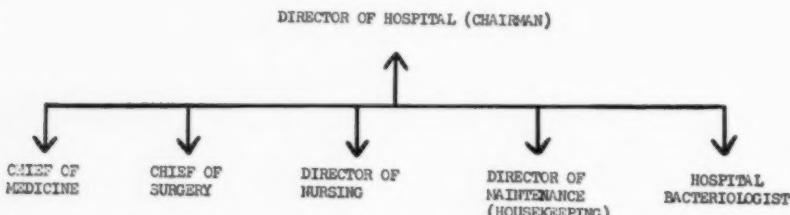


Figure 1—Chart showing composition of a Continuing Committee on Infections. Functions are (1) to receive reports from all areas through administrative offices; (2) the evolution of policies on basis of reports received; (3) to give advice to medical staff and hospital board.

from 24 per cent^{1,2} to 60 per cent³ of persons, its control is difficult and involves every person in the hospital, including the visitor. Plans therefore must embrace much more than improvements in medical and nursing techniques. Plans are likely to be successful only if they are instigated with the co-operation and assistance of the administrative head of the hospital.

Much has been written and many suggestions made for the control of the staphylococcus. Perhaps the first question that requires answering in our hospitals is "How do we organize a control program?" This paper will comment on the main steps that have been taken at University Hospital, Saskatoon.

For the hospital that wishes to institute a control program, or wishes to ascertain the need for a special program, it is suggested that a Review Committee, composed of the administrator and representatives of the medical and nursing staffs, attempt to assess the problem. Is there a problem? If not, should not steps be taken to prevent the development of an infection problem? The writer, together with his medical staff, had assumed an attitude of "it can't happen here" until it did. Many others have had the same experience, and extensive evidence points to a widespread increase in hospital infections due to the staphylococcus.

At University Hospital a Review Committee first arranged to receive reports on infections from the heads of the medical departments. It was quickly learned that if *all* infections, no matter how minor, were reported, there was a considerable and more or less constant reservoir of infection, mainly staphylococcal, in our hospital. It was decided that, while the staphylococcus was the main

problem, control should not be selective but should be directed at all infection.

Because infection may be carried to the bedside by anyone, whether a doctor or a housekeeper, it was obvious that an effective program would depend upon hospital-wide participation. Inasmuch as no quick, effective remedy was known, it was also apparent that satisfactory control would require permanent vigilance. Finally, it was agreed that infections are usually preventable and therefore are often inexcusable complications that bring distress and danger to our patients. In short, something can and must be done.

Therefore a Continuing Committee on Infections was established, composed of two representatives from the clinical staff, the director of nursing, the bacteriologist, the superintendent of maintenance (in charge of housekeeping) and the hospital director, who was made chairman (see Fig. 1). The composition of this committee is similar to others appointed elsewhere, e.g., at Queen Mary Veterans' Hospital, Montreal, Quebec.

The membership of the Continuing Committee on Infections will vary depending on the size of the hospital and the personnel available, but the work can proceed along similar lines whether the hospital be large or small, rural or urban. Suggested procedures are as follows:

1. Each medical department head (or the chief of staff if there is no division into medical departments), should make a careful evaluation and listing of *all* cases of infection each month on a written form (Fig. 2). This form may be varied to suit the needs of the individual hospital or of departments within the hospital and should be submitted to the admin-

istrative offices. If desired, copies may also be submitted to the chairman of the Medical Record Committee or to other committees of the medical staff. It is important to distinguish between the patients who are admitted with infection and those developing infection while in hospital. Obviously, increases in the numbers of the latter group give much greater cause for concern. For this reason, most medical chiefs also complete a brief monthly summary form which clearly distinguishes between infections present on admission and infections developing during the hospital stay (Fig. 3). Our experience has shown that we consistently have more patients with infection on admission than patients who develop a hospital infection.

2. A statistical summation of the reports received from the medical chiefs is prepared by the administrative officer in chart and/or in graph form on monthly, quarterly and annual bases for purposes of comparison (Fig. 4 and 5). It will be noted that, in an effort to keep a better check on the total reservoir of infection in the hospital, cases carried over in isolation from preceding months are also shown in a separate column for each department and for the hospital as a whole. It should be emphasized that these figures show *every* infection no matter how minute and despite the fact that many of the infections reported caused no symptoms, no inconvenience to the patient and did not in any way, other than by the observance of isolation precautions, alter the normal course of their hospital and medical care.

3. The nursing department maintains a daily count on the total number of patients in isolation in the hospital, both by ward areas and in the building as a whole. This is computed monthly on graph and/or chart form (Fig. 6) and submitted to the administrative offices. This is another method of assessing the total reservoir of infection in the hospital. It is important to note that the nurses' report may give an entirely different picture from the medical report. The medical reports may show 20 new cases of infection during the current month as compared to 30 new cases which developed during the previous month, thus indicating that the dangers from infection are somewhat less. However, if the 20 new cases require an average of ten days isol-

tion each, whereas the 30 cases during the previous month required an average of only five days isolation each, the nurses' reports would indicate 200 patient days of isolation in the current month as compared to 150 days during the preceding month. Although fewer in numbers, the infections were possibly more serious or more resistant to care and the reservoir of infection, while not as great in numbers of patients, is perhaps greater in potential. Thus the double source of information serves as a double check.

4. Regular meetings of the committee are held every two months or oftener if the need arises.

5. The committee reviews the numbers and types of infections for each month in the hospital and in each area of the hospital. It is important not only to know if infections are increasing but also

to know if any particular area is hard hit, and to determine the reasons.

6. The committee reviews thoroughly all methods of control, e.g., isolation techniques, laundry methods; and recommends necessary changes and additional policies.

7. In recommending methods of improvement it is important to proceed methodically. When all basic techniques are agreed upon and in use, further changes are effected one at a time, if possible, in order that improvements may be evaluated individually and objectively.

8. Studies of new methods or of conditions in the hospital wards are carried out by the committee. Additional personnel are added to the committee when indicated. For example, the advice of the laundry manager was of great value when

oiling of linen and blankets was discussed.

9. Regular reports are made to the medical staff in order to obtain their co-operation in the establishment and maintenance of sound policies.

Housekeeping And Laundry

We have mentioned that all hospital departments and personnel are involved in an infection control program. Two hospital departments become of particular importance in a control program and deserve special mention.

Housekeeping and Maintenance

Hospital maintenance, with particular reference to housekeeping, can make or break a control program. The following recommendations are suggested:

1. All housekeeping staff should receive instruction on (a) isolation

REPORT OF INFECTIONS

Department of Medicine

Month, August, 1957

Name	Hosp. No.	Isolation	Diagnosis or Operation	Site	Organism	Sensitive to	Responded to	Doctor
(Admitted with infection)								
Brommeland	4772	Aug. 14 Aug. 10	Toxic Myocarditis	Boil on rt. shoulder	Micrococcus aureus coag. pos.	Aureo. chloro. ery. tetra. sl. to pen	Ery.	McG.
Koeferle	4839	Aug. 19 Aug. 25	Furuncle on fore- arm	Forearm	Micrococcus aureus coag. pos.	Aureo. chloro. ery. tetra. fura. bact. neo.	Ery.	McG.
Katchuik	23145	Aug. 26	Cranial nerve Palsy	Sputum ulcer on cornea	Micrococcus aureus coag. pos.	Aureo. chloro. pen. strept. terra. ery. tetra. fura. bact. neo.	Pen.	B
Wolchak	25332	Not Isolated	Tuberculosis	Sputum	Acid fast Bacilli	Transferred to san. Aug. 28 (Adm. Aug. 23)		D & H
(Acquired infection in hospital)								
Caron	15659	Aug. 15 Aug. 21	Mononucleosis on dis. poss. pneumonia and acute pyrexia on adm.	Sputum	Micro aureus coag. pos.	Aureo. chloro. tetra. terra. strep.	nil	C
Bergen	21917C	Not Isolated	Pancytopenia	Blood	Scanty growth Micro. aur. coag. pos.	Aureo. chloro. pen. tetra. strep. terra. ery. Novo.	Chloro	McC
(Carry overs)								
Anderson	14022C	July 22						
Moser	23683	Off Aug. 23						
Wallin	2834V	May						
Bateman	21861	May						
Gray	22364V	Off Aug. 20						
Johnston	22740	June 19						

Figure 2—A sample of information contained in the monthly report compiled by a medical department chief. These reports are forwarded to the administrative offices for consideration by the Continuing Committee on Infection.

Report of Infection
(Summary of Incidence)

Department Medicine

Month September, 1957

	Staph.	Other	Total	Percentage
Admitted with Infection	7	4	11	
Following Operation	1	0	1	
Arising in Hospital Other Than Following Operation	2	0	2	
Rate per Discharge				
Rate per Surgical Procedure				

Figure 3—Summary form used by department chief to distinguish between numbers of infections contracted by patients prior to admission as opposed to those infections developing in hospital during one month.

precautions and how to observe them, and (b) on general hygienic methods for cleanliness of person, clothing and equipment.

2. All dry cleaning techniques should be abandoned in favour of damp dusting, oiled mopping and other washing or dust settling methods of cleaning.

3. Bed-making and other handling of linen and blankets should be accomplished with as little shaking of the linen as possible to prevent stirring up lint and dust-borne bacteria.

4. Decontamination methods should be worked out carefully and should be strictly observed; e.g., terminal disinfection by wall washing, fumigation of rooms.

5. Ventilation of operating rooms

should be checked regularly, particularly if a forced ventilation system is in use, in order to ensure that there is a positive air pressure in the operating room at all times and that corridor air does not flow into the clean operating room.

6. Wherever possible in new buildings or in renovations, hard, easily washable surfaces are recommended. Tiled walls and terrazzo floors are much easier to clean and keep clean than softer more porous materials such as wood, plaster, paper.

7. Because of the amount of contact between patients and house-keeping staff, the head of the department should be closely informed on all aspects of the program

by being a member of the Infection Committee.

Laundry

Hospital patients are constantly in contact with blankets and hospital linen and these items are sources of lint and dust that carry bacteria. For this reason the laundry looms extremely important in infection control. Methods of linen collection must be carefully worked out to minimize shaking and agitation of linen with resultant clouds of bacteria carrying lint and dust. Contaminated linen must be kept separate from other soiled linen and both types must be kept separate from the clean linen supply. There must be separate sorting of contaminated and non-contaminated linen both in the hospital and in the laundry. One device that assists in achieving this objective at University Hospital is the use of special red bags for contaminated linen.

The normal laundry process is lethal to most non-spore forming organisms and the bacterial counts on the final laundry rinse water are less than those usually found in city drinking water. Thus, a good laundry service can give assurance that linen is clean almost to the point of sterility when the washing is completed. However, great care must be taken that linen sorting in the ward and in the laundry is well separated from the clean linen areas and that cross traffic between the storage and sorting areas is eliminated. If policies are not carefully adhered to, clean linen stored in the ward or in the laundry may become a source of danger.

Oiling of Linen and Blankets

Many authors have claimed substantial reduction in the numbers of air-borne bacteria in hospital areas following introduction of the linen oiling process. However, Rowntree⁶ has reported that, whereas blankets following oiling and treatment with Fixanol C (ethyl pyridium bromide) showed a 90-95 per cent lower bacterial count than before treatment, nonetheless infections were little, if any, reduced. She postulated that direct contact through cough droplets, contaminated hands, et cetera, was the main cause of cross infection in hospital. Despite such findings many believe that it is desirable to keep air-borne bacteria to a minimum. The oiling process is under study at University Hospital and it is possible that the oiling of all blankets and linen begun a few

Infections — By Departments

	June, 1957			July, 1957			August, 1957			August, 1956		
	Adm. With Inf.	Hosp. Over	Carry Over									
Medicine	10	6	8	9	6	14	8	4	5	10	6	
	(4 meas.)											
Rehabilitation												
Medicine	3	0	8	2	0	6	1	0	3	2	1	
Surgery	2	5	0	8	0	2	7	6	6	10	10	
Neurosurgery	0	0	1	0	0	1	0	3	1	No report		
Paediatrics—												
Ward	0	8	2	4	4	0	5	1	0	5	5	
	(2 meas.)											
	4 c.pox)											
Nursery	0	3	0	0	4	0	0	4	0	0	3	
Gynecology	0	0	0	0	0	0	1	0	0	2	1	
Obstetrics	2	0	0	1	0	0	1	1	0	0	0	
	17	22	19	24	14	23	23	19	15	29	26	
	17			24			23			29		
	39			38			42			55		

Figure 4—Summary form compiled in administrative offices showing total infections by departments and in hospital for current month (August) as compared to two previous months and one year previous.

Note: No distinction as to severity of infection is made and all infections, no matter how minor, are listed.

months ago may be associated with a fairly marked decrease in air-borne bacteria during recent months. However, definite conclusions cannot be drawn as yet. It is significant to note that the lowering in numbers of infections appears to be considerably less proportionally than the lowering in numbers of air-borne bacteria.

The oiling procedure is simple and consists mainly of adding a small amount of a light spindle oil to the final rinse water during each washing process. Four ounces of oil per hundred pounds of linen or approximately three-quarters of a pint to each washing machine load is used. A bactericidal agent such as Fixanol C may be added to the oil if desired. Most commercial preparations of the oil have a bacteriostatic agent already added.

Several advantageous side effects of oiling linen have been observed which will more than justify its continued use even if little or no reduction in the numbers of infections is secured.

1. The linen is softer to the touch and diaper rashes and other skin irritations have been sharply

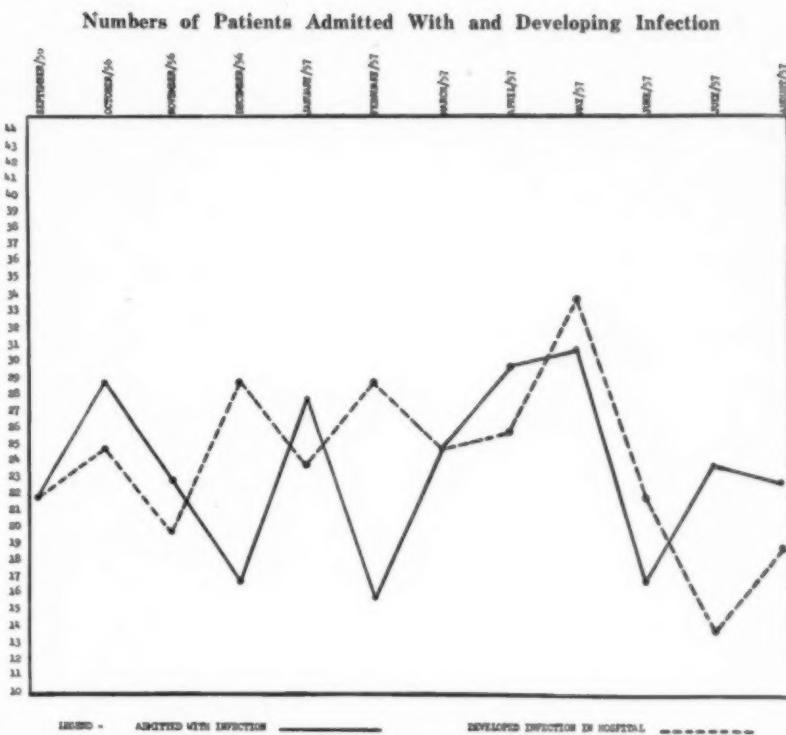


Figure 5—Annual graph showing total number of patients admitted with infection and developing infection in hospital by months, September, 1956, through August, 1957. Peaks of hospital infections in December, May, and June were occasioned by outbreaks of measles and chicken pox in paediatrics. February was the only month when staph. and other hospital infections exceeded those admitted with infection. No apparent relation between numbers of infections and total patient admissions to hospital could be found.

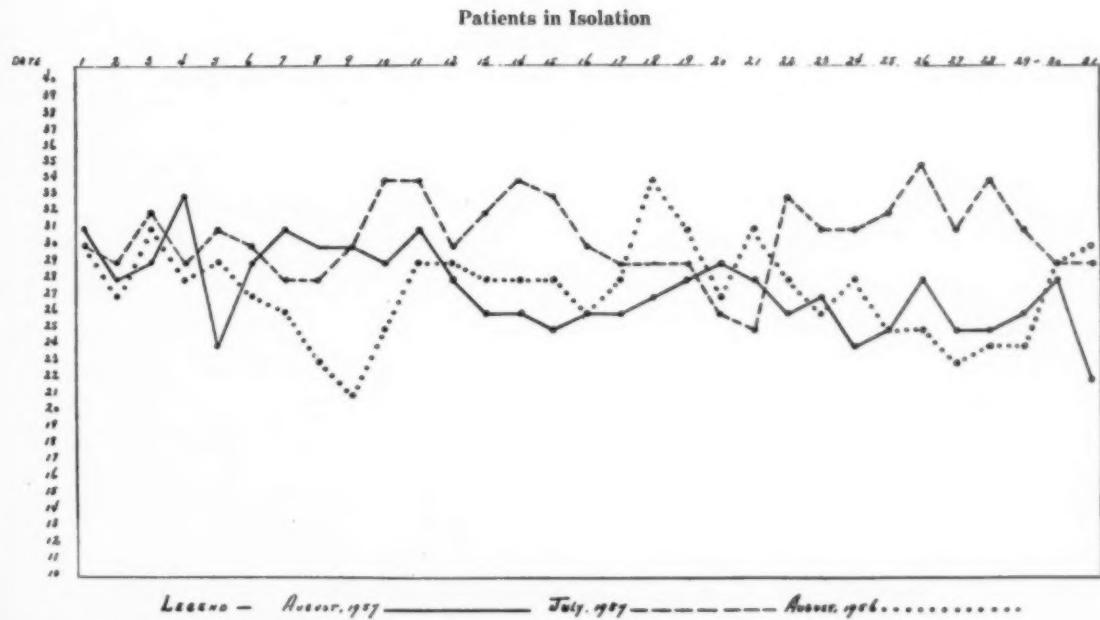


Figure 6—Graph compiled in the nursing department showing total number of patients in isolation in the hospital, day by day, for the month of August, 1957, as compared to preceding month and one year previous.

reduced since oiling of linen was begun.

2. The linen maintains its whiteness and washes much more quickly and easily with a resultant saving of 27 per cent washing time. This speeds laundry service to the hospital and also effects an economy.

3. Oiled linen shows much less wear following repeated washings than does non-oiled linen and lasts a great deal longer. At University Hospital the average loss in tensile strength following 20 washings was reduced from 9 per cent to 6.5 per cent following introduction of the oiling process.

4. Ironing is quicker, easier and better.

5. The cost of the oil is small and is more than compensated for by the savings in time, in prolonged linen life and in improved patient care.

Summary

These are some of the administrative aspects of a program for control of infections at University Hospital, Saskatoon. We recommend the formation of a Continuing Committee on Infections to develop and enforce the control program. The duties and procedures of our committee and the infection report forms used at University Hospital are suggested to guide such a committee. In describing the particular roles of the laundry and housekeeping departments I have noted several advantages of the oiling of linen, a procedure put on trial in our hospital. There must be whole-hearted interest on the part of each member of both medical and hospital staffs if any hospital is to develop a program for control of infections that is co-ordinated and effective.

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Bacteriological fact finding

George Dempster, M.D., B.Sc.*

THE source of pathogenic staphylococci in hospitals may be either the carrier, the case, or the environment. The clothes, bed linen, cutlery and mattress of a patient with staphylococcal infection may be heavily contaminated by direct contact, as also may be the hands or clothes of attendant personnel. Since the infective agent is particularly resistant to drying, it follows that any part whatever of the immediate surroundings can be contaminated indirectly by the air and the dust particles carried in it. The question is what bacteriological controls can we exercise to limit the spread in hospitals. How can we control the carrier, the case, and the environment?

On the surface of it, there might not seem to be a very great problem in the control of staphylococcal infection. After all, this is a non-sporing organism with only a slightly greater degree of heat resistance as compared with other non-sporing species. However, the organism does possess three important biological properties which endow it with greater potentialities. These properties are the production of the carrier state in man, resistance to drying, and the ability to form strains resistant to antibiotics and various chemical substances.

The magnitude of the problem is revealed when one investigates the nasal carrier rate of coagulase-positive staphylococci, all of which are assumed to be potentially pathogenic. It is generally appreciated that the rate is in the region of 50 per cent, and that of these, some 25 per cent may be permanent carriers. Investigation in our own hospital reveals a similar state of affairs (18-22 per cent permanent carriers). Translated into terms of the large hospital, this means that there are several hundred carriers in a 500-bed hospital. The very fact that such a large number of carriers exists and has existed in the population for years, emphasizes the point that very special circumstances must prevail to per-

mit the establishment of infection. Since the carriers cannot be effectively eliminated, the only alternative is to protect debilitated patients from exposure to large doses of the organisms shed by the carrier. This is accomplished by the ordinary techniques of asepsis and masking which are well-established, and have only been neglected since the physician adopted the antibiotic umbrella as the emblem of bacteriological peace in our time.

Carriers

It should be emphasized that carriers may become cases of minor infection and when this happens, their potentiality to spread disease is tremendously enhanced. Therefore, our aim must be to encourage personnel to report immediately minor septic infections which they develop. It might be possible to institute a free-from-infection routine examination, but it is far more practical to encourage the staff to report their infections. One would expect in a 500-bed hospital with a staff of about 1000 persons, to have something in the region of 10 cases of this nature reported every month. Figures should be kept of the personnel infection rate, and if it is abnormally low, then search should be made for unreported cases. In our own hospital, we encounter 11.8 cases of staphylococcal infection in staff per month. Conversely, if the infection rate in the staff is abnormally high, this should stimulate enquiry. The latter is the normal procedure; perhaps it is wiser to emphasize the need to investigate an abnormally low rate of reporting.

Cases

While the importance of the carrier can be over-estimated, the effects of minor lesions and cases should not be overlooked, for it is the latter, together with the more serious illnesses, which supply the main source of infection. The fact that penicillin-resistant strains provide the major source of cross-infection would support this view, for these strains have been selectively cultivated in innumerable infections in hospitals.

On this account, isolation pro-

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cedures employed for even mild staphylococcal infections are of great importance. It follows that the successful control of staphylococcal infections depends upon the care with which the medical and other staff observe the isolation techniques which have been outlined in this symposium.

Environment

If the cases are properly isolated and all personnel (any of whom may be carriers at one time or another) are instructed in the proper observation of isolation techniques, then all that remains is the question of how to deal with the environment.

The environment of the case can be considered under three headings:

(a) that part which may be sterilized by heat or laundering techniques;

(b) that part which can only be treated by chemicals;

(c) the air.

Since the staphylococcus is readily destroyed by heat, all articles in the environment of a case which can be subjected to either boiling or autoclaving should be treated in this manner. Laundering of bed linen and blankets in soap and water at a temperature of 160° F is usually adequate. If oil is incorporated in the final wash, this will prevent the liberation of lint particles which, on being shed from used bed linen or blankets, will act as floating carriers of micro-organisms in the air.

The isolation room itself, the articles of furniture, the drapes and the mattress, can be readily treated only by chemical disinfect-

ants. All isolation rooms should be terminally disinfected and, where possible, fumigated. The patient's outer clothing which cannot be washed is also subjected to fumigation. This is considered important since patients may reinfect themselves, or pass infection to their families from their own clothing.

Terminal Disinfection Procedure

When a patient is taken off isolation technique in our hospital he is moved to a clean unit. The contaminated unit is then stripped of bed clothes and any equipment that can be autoclaved or sterilized by boiling. Other equipment such as an oxygen tent, remains in the unit. The patient's belongings are hung on hangers on a rack, spaced so that air circulates around them freely. The pillow is placed on the linen hamper. The mattress is left clear. The electrical outlets, intercom plate and air vents are covered with heavy wax paper that is held in place with mastic tape. The washroom door to the adjoining room is sealed with mastic tape. The windows are tightly closed. The hygrothermograph and humidifier are placed near the centre of the room. The toilet seat is completely washed with 2½ per cent lysol; then 20 grams of calcium hypochlorite and 200 mills of formalin are mixed in an enamelware basin. This is placed on the bathroom floor. Another basin of the same mixture is placed under the bed. The door then is closed and sealed with mastic tape. A strip of heavy waxed paper is used to close the gap under the door and held in place with mastic tape.

This seal must not be broken for at least ten hours. During this time it is necessary for the humidity to reach at least 75 per cent to be effective. A steam humidifier along with a temperature and humidity recorder is used.

On entering a room after the allotted time, a gas mask is worn. The windows are opened, the humidifier is disconnected and the formalin mixture is flushed down the toilet. The room is aired until fumes disappear. The furnishings, bathroom and floors are then thoroughly washed with 2½ per cent lysol, and the bed screen changed. The bed is remade and unit is ready for admission.

A specially built cabinet has been designed to disinfect patient's belongings in ten hours. This is used for those who are discharged directly from isolation units and whose rooms are fumigated after they have left the hospital. This cabinet measures 3' x 4' x 5' 6", with an opening on one side just large enough to fit the hose of the humidifier. The door is fitted with a rubber gasket to prevent leakage of fumes. A small shelf inside and in front of a glass window holds the hygrothermograph and permits a constant check of the humidity reading. The built-in fan on the top draws out the fumes when fumigation is completed. The clothing to be fumigated is hung on the rack in the same manner as described previously, then covered for transfer from unit to cabinet. Both rack and clothing are placed in the cabinet and the cover removed.

The above fumigation procedures completely sterilized artificially contaminated squares of linen exposed in various situations in the room provided the humidity was kept over 70 per cent during the whole procedure. This was satisfactory when broth cultures were used to contaminate the linen. However, it was found that organisms protected by a heavy coat of protein material (e.g., as in pus), were not all destroyed. A method of terminal disinfection, such as this, which combines fumigation and the use of antiseptic solutions, will prevent a build-up of pathogenic organisms in the room. As a routine bacteriological check, swabs have been taken from the pillow, the mattress, and the toilet seat of isolation units treated in this manner. Staphylococcus aureus was recovered from 4 of 196 pillows, 5 of 225 mattresses, and 2 of 197 toilet seats tested after treatment.

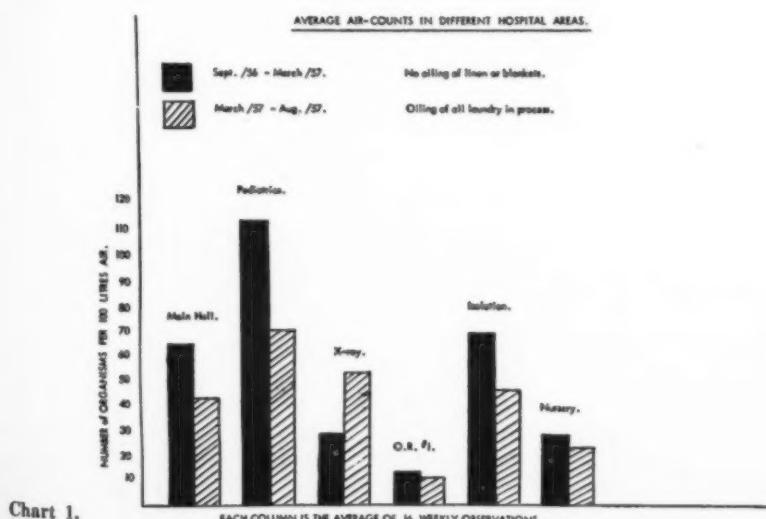


Chart 1.

during an eight-month period of investigation.

Patients, personnel and hospital visitors all share equally one part of the environment of a hospital, namely, the air. While this medium in ordinary circumstances may not be very important in the spread of staphylococcal infections, it is conceivable that under bad conditions, where a build-up of organisms has been allowed to develop, then the air may play a considerable rôle.

As part of the program to prevent such a development, steps were taken early to check the air counts of all organisms (not only staphylococci) in representative parts of the hospital throughout the year. These air counts were performed with a millipore filter technique by which 100 litre 10 minute samples of air were taken

at a set time of day in the different areas. The samples were taken by one technician who sampled in a standard way, and who also made notes about the surroundings and activities going on during sampling. Operating theatres were sampled immediately after the conclusion of the last operation.

It was observed (as illustrated in Chart No. 1) that the average air count in each area fell during the second part of the year. In x-ray, however, a rise was noted, but this was correlated with construction activities which were taking place in this department.

The second part of the year's survey corresponded to the spring and summer months, and the decreased average counts in the different areas could be correlated with the seasonal change; but it

also corresponded with the institution of the oiling of all blankets and linen which commenced in March, 1957.

Further observations will help to clarify whether the oiling contributed significantly to the fall noted in the average counts. The most dramatic drop in air-count was observed in the paediatric wards. This is well illustrated in Chart No. 2, in which individual weekly readings were recorded over a period of one year.

One further service which the bacteriology laboratory can usefully perform is a check upon percentage of resistant staphylococci isolated month by month. In this way, the Infection Committee and the heads of departments are kept informed of the over-all position in the hospital with respect to the antibiotics in use. The figures shown in Chart No. 3 are gathered from observations upon 369 patients from whom a pathogenic staphylococcus was isolated, and in which the sensitivity was recorded by the disc method. Resistance in this context implies resistance observed with a disc containing the following concentrations of antibiotics: penicillin, 5 units; streptomycin, 25 micrograms; terramycin, 50 micrograms; erythromycin, 50 micrograms and chloromycetin, 50 micrograms.

Summary

In conclusion, the control of the spread of staphylococcal infection by carriers is dependent upon the observance of the ordinary well-established procedures of hospital care, but a more vigorous isolation technique must be used and enforced for all active infections, even of a minor nature. In isolation techniques, whilst the aim must be towards "operating-room care", it must be remembered that the patient may be in isolation for many days and cannot be treated as a patient under an anaesthetic. The patient's morale is an important consideration, a compromise must be struck between the ideal and the practical. Since cases are the major sources of infection, current and terminal disinfection of rooms are important procedures which must be carefully carried out and checked bacteriologically from time to time. As an ancillary measure, air-count checks may be helpful. Monthly records should be kept of the percentage of staphylococcus strains which prove resistant to the current antibiotics in use, and this information made available to medical staffs.

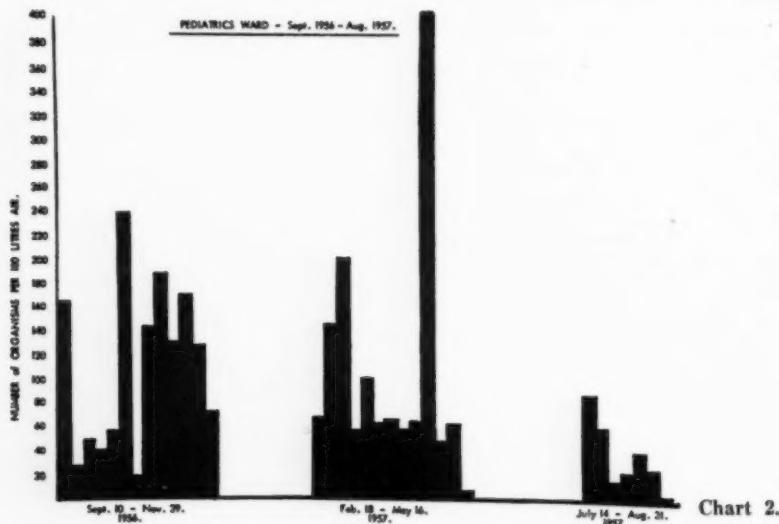


Chart 2.

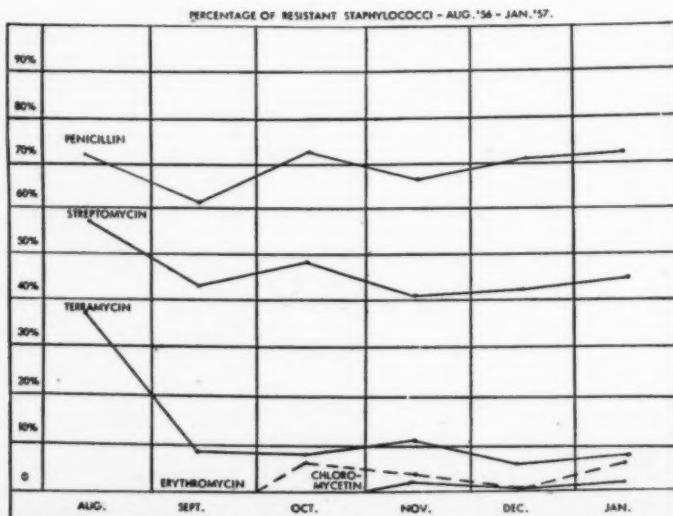


Chart 3.

THREE is nothing new or spectacular about the isolation routine carried out at the University Hospital. The basic principles are similar to those which have been stressed in isolation hospitals for over thirty years. Perhaps this fact alone is worth noting in the light of the vast amount of material that has been written on the problems of staphylococcal infection in hospitals, for in the attempt to find a solution many theories have been advanced, have held their sway for a time and then have been set aside as not being too effective after all.

When a patient is suspected of having an infectious condition, the first step is to isolate him. To leave him in a multi-bed ward or to hesitate to set up precautionary measures until a positive diagnosis is made on the basis of various tests, is to court disaster—not only for other patients but also for the members of the hospital staff. Placing the patient in a single room is desirable—one with a sink equipped with foot controls would be the logical choice. Before the patient is admitted to this room, all unnecessary furniture and equipment should be removed as any article in reach of the patient is considered contaminated. Traffic in and out of the isolation unit should be restricted to the minimum; this includes limiting the number of visitors the patient may receive. Although it is necessary to sustain the morale of the patient during this trying period, too many visitors may spread the infection to the community. In our hospital we found

Nursing techniques

M. K. Ruane, R.N.*

that when visitors were permitted to wander into the isolation units at will, it was impossible to give them adequate instruction on gowning and masking, thus exposing them to infection, or that they arrived in such large numbers that we soon exhausted our supplies of gowns and masks.

Each patient should have his own bedside utensil set—mouth wash cup, wash basin, urinal and bedpan. At the end of the patient's stay, this equipment should be thoroughly washed in soap and water, placed in a heavy canvas bag and sent to be autoclaved. Articles that cannot be autoclaved should be washed and soaked in zepharine-chloride solution 1-1000, for twenty minutes. Other equipment such as steam kettles, electric appliances, ought to be left in the room and fumigated. The fumigation of rooms is the responsibility of the housekeeping department.

As a daily isolation routine, gowns and masks are worn by the hospital staff who come into direct contact with the patient. Soiled linen is placed in a red mesh bag and at the end of the day it is placed in a heavy canvas bag, labelled with a red tag and sent to the laundry. A clean gown is kept

hanging at the room entrance for the convenience of the hospital staff. Refuse, such as soiled dressings, or faded flowers, are disposed of in a paper bag and subsequently taken to the incinerator (See Fig. 1).

It may not always be possible to transfer a patient to a single room. An alternative is to screen the patient off from the others if he is in a multi-bed ward. He should have his own bedside equipment, and some method of gowning and masking should be established. If a sink with running water is not available, two wash basins—one containing soap solution, the other clear water to be used as a rinse, will serve the purpose. Hand washing is the most effective defense against the spread of infection from one person to another. The hands should be washed before and after caring for the patient and more often if necessary. This is an old precept advocated first by Semmelweiss in his campaign against the spread of child-birth fever. Some more modern authorities on the subject recommend the use of phisohex or a solution of hexachlorophene for hand washing. We use a solution of ordinary surgical soap and it is proving satisfactory. At our hospital, gloves are not worn except when changing dressings saturated with infectious material. Frequent use of hand lotion is encouraged to prevent skin irritations.

The broader term "hospital staff" in preference to the medical and/or nursing staff has been used here purposely. We are all familiar with the shortage of professional nurses and are aware that in attempting to solve this problem, to some extent at least, non-professional people are carrying out duties that were once considered the responsibility of the nurse. Food trays are now being carried to the bedside by the kitchen maid and the cleaning of the patient's room is done by the housekeeping staff. These people, useful and numerous as they are, have little knowledge concerning



Figure 1—Gown hangs on stand at doorway. Large red mesh linen bag and smaller paper bag are for the disposal of small contaminated items.

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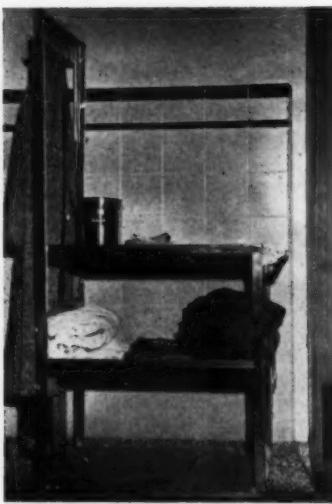


Figure 2—Isolation cart for non-contaminated items. Hooks for visitors' or doctors' coats at left.

bacteriology. Under these circumstances, any system of isolation technique must of necessity be simple, sound and standard for all services. It is also important that all new staff members—interns, doctors, x-ray and laboratory technicians, nurses and housemaids—be instructed on the prevailing method of isolation procedure.

Frequently we found that members of our staff were having difficulty observing all the details of the isolation procedure. Masks were not being worn because they were not readily available, visitors were at a loss as to where to hang their coats before they entered the patient's room, and laboratory technicians would place their equipment on contaminated tables for lack of other space. To help solve these problems, a cart was constructed by the hospital engineer. This was placed just outside the unit and now a clean surface is provided for equipment, there are hooks for visitors' and doctors' coats and extra supplies of masks, gowns, canvas and paper bags can be found on the cart (See Fig. 2). When not in use, these carts are stored in the central supply room.

Years ago when infectious diseases were more prevalent than they are today, it was customary to send patients so afflicted to isolation hospitals. Later the trend was toward building isolation wings or wards in general hos-

pitals. These methods are satisfactory when the patient's only disability is an infectious disease such as measles, typhoid or poliomyelitis. But the problem of staphylococcal infection is very different. A patient's initial or major illness may be of a surgical, medical or obstetrical nature, with staphylococcal infection as a complicating factor. Thus, in an age of specialization, the attending physician does not look kindly on the prospect of having his patient moved to an area where the intern and nursing staffs are unfamiliar with his method of treatment and the equipment is unsuited to his needs. The patient, too, is unhappy about leaving the nurses he has come to know and trust. Therefore it seems, at least as far as staphylococcal infection is concerned, more desirable to isolate the patient where you find him.

However, unit or room isolation creates complications for the nursing supervisor. It is much more difficult to educate and discipline staff when so-called clean and dirty cases are housed in the same area. Nevertheless, in the interest of the patient's welfare and the health of the hospital staff, some system of instruction and discipline must exist.

A sort of "cops and robbers" game in which the nurse plays the rôle of the "cop" seems to be universal. It goes something like this: a doctor, pressed for time, wishes to run in and examine Mr. So-and-So, who happens to be in isolation. And so, unnoticed and without any fanfare, he proceeds to examine the patient. A nurse comes along and if she is a hard headed type of "cop" she will ask the doctor to remove his coat and put on a gown and mask. If she is a timid type of "cop", she will quietly stand by and ask herself why the doctor can sit on the bed and not observe the isolation technique while she and her colleagues must.

At times there is a reluctance to place the patient in isolation. And perhaps this reluctance arises from the custom of moving the patient from familiar surroundings to isolation areas which lack the usual comforts of hospital living. Windows may be bare of curtains, the furniture drab and the dishes discoloured and chipped due to frequent sterilizing. The patient, regardless of his disease, has a right to a decent environment and this should be provided if it is at all possible. For instance, attractive paper dishes that are waxed to

prevent spoiling the taste of food can now be obtained and these can be disposed of after use (See Fig. 3).

A moment or two should be spent with the patient to explain the reason for his being placed in isolation. We have found that patients are remarkably well informed on the problem of staphylococcal infection in hospitals and they readily recognize their rôle in protecting the other patients. In fact, so well informed are they through press, radio and television, that they may be disposed to question a regime which fails to provide protection when the need arises.

A few lines from an editorial on staphylococcal infection in *Hospitals*, June 16, 1957, will serve to summarize what has been said above: "The methods of minimizing the transmission of infection involve no magic and little that is new. The old fashioned, tried and true perfected aseptic techniques, old fashioned soap, water and "elbow grease" cleanliness, and proper gowning and masking . . . seem to be the most effective methods . . . The most important means of controlling infection is competent, conscientious personnel—competent so that they know what to do and why; conscientious so that they will do what they know."



Figure 3 — Isolation tray. Only the tray, cutlery and teapot need be sterilized. The tray cover and all other dishes are of paper and easily disposable.

THE monthly records of micrococcal infections kept by the department of medicine at University Hospital have been reviewed. Most cases of staphylococcal infection seen on the medical wards involve either the skin or respiratory system. In addition to this, positive cultures are obtained not infrequently from urine. Infection of biopsies, ascitic fluid, blood and stool have also been noted. In keeping these records some attempt has been made to ascertain whether the patient was admitted with infection or whether the infection was acquired after hospitalization. All of these cases are on the basis of positive culture for *micrococcus aureus* coagulase positive.

This is a breakdown of cases from June, 1956 to June, 1957:

	Admitted	Acquired
Skin	99	26
Respiratory	46	19
Urine	6	6
Miscellaneous	-	4
	—	—
	151	55

It may be seen from these figures that the great majority of infections are either of the skin or respiratory system, and that roughly three staphylococcal infections are admitted for every one acquired in hospital.

Problem Cases

Most cases of staphylococcal infections are innocuous and consist of furuncles or minor pyoderma. Many of the cases listed are positive cultures of doubtful clinical significance. On occasion, however, these infections may cause serious illness. Our experience has been the same as elsewhere that staphylococcal infections of any consequence, particularly bronchopneumonia and septicemia, occur in patients who suffer from serious disease. In a brief review of our fatal cases I was unable to find a case of death in an adult who was otherwise in good health. Certain clinical situations seem to cause a change in the host that allows the growth of staphylococci, leading to clinical infection. Among these situations are the presence of malignancies, use of protoplasmic poisons such as nitrogen mustard, use of A.C.T.H., and major surgical procedures. One girl of 14 was admitted with staphylococcal septicemia resulting in anterior spinal artery thrombosis and paraplegia. No apparent primary

disease was present except low white blood count at admission which suggested pre-existing leukopenia.

Most deaths have occurred as a terminal event in individuals dying of some serious disease but an occasional infection may occur, with death, in individuals who might reasonably have been expected to recover from their original disease. Apart from a fatal issue it is difficult to estimate how much staphylococcal infections have prolonged the recovery of patients from other diseases, but we have all seen patients whose hospital stay was greatly increased by superadded staphylococcal infection.

Paediatric Problems

In the nursery the chief problem is that the "new borns" get staphylococcal conjunctivitis, rhinitis and furunculosis. These infections lead to contamination of other children in the nursery or of the mother, or to more serious disease of lung or gastro-intestinal tract in the child himself. There has also been a good deal of serious respiratory disease in the form of staphylococcal pneumonias and pyopneumothorax in the group of children under one year of age. Only about a third of these cases have been acquired in hospital (4 out of 12).

Methods of Control

Most cases of staphylococcal infection are merely a nuisance but in the adult with other serious disease it may materially shorten his life. It is in an attempt to prevent these unfortunate incidences that we have developed the isolation practices described by Miss Ruane in this symposium.

There has been some difficulty in maintaining enthusiasm for the techniques of isolation. This is especially true when the patient has been isolated for a positive culture only. However, if each member of the medical staff is maintaining as strict isolation procedures as possible, the contribution of the whole group is worthwhile. The fact that isolation sometimes prevents as close observation of the patient as

is desirable can be overcome by the development of regular habits of visiting. Then, too, for certain patients isolation leads to definite depressive symptoms.

One problem that always arises is, "when do we isolate?" Our principle has been to isolate all individuals in whom we suspect staphylococcal infections. As I have indicated, we are suspicious of any patient who has serious underlying disease in whom a respiratory complication develops. All skin infections which appear purulent are isolated until cultures are done. In addition, any diarrhoea following the use of antibiotics is considered to be staphylococcal until cultures prove it otherwise. In any case in which positive cultures are returned from any source, isolation is also begun. The period of isolation is usually continued until cultures are negative. This, of course, has caused long periods of isolation in some cases of skin and respiratory tract infection.

It seems likely that some of the problems relating to the control of staphylococcal infections are caused by antibiotics. There has been much discussion as to whether the incidence and type of micrococcal infections have changed with the advent of antibiotics. There seems to be no definite answer to this but it is quite apparent that the development or selection of resistant strains is related to the use or abuse of antibiotics. The sensitivity of *micrococcus aureus* to an antibiotic is usually inversely proportional to the use of that antibiotic in that particular institution. Therefore we have advised the use of antibiotics in University Hospital only where the indications are clear and then, if possible, on the basis of sensitivity testing. We have tended to discourage the use of antibiotics for prophylactic purposes (for example in virus pneumonia). On the whole we feel that reasonable restriction of antibiotic use has been achieved by these methods. Most of us have forgotten that there are still many strains of staphylococci, especially outside institutions, that are still sensitive

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On the medical wards

D. J. Buchan, M.D.*

to penicillin and in this situation penicillin is still the treatment of choice and if used should be in heavy dosage with quick-acting preparations.

Some attempts have been made to advise the limitation of use of certain antibiotics which possess anti-staphylococcal activity, such as erythromycin and novobiocin in order to prevent the development of resistant strains to these antibiotics. It has been difficult to assess the success of such a procedure. In other places the use of designated antibiotics have been prohibited except in certain situations. We have not yet felt that this prohibi-

tion is necessary in our institution.

Antibiotics are not the answer to this problem; changes in the host seem to be of paramount importance. The same strain of micrococcus living peacefully in the anterior nares of a member of the hospital staff who is healthy may cause profound tissue changes in a patient who is suffering from a serious pre-existing disease. The fact that patients of this type are dying of micrococcal infections in spite of in vitro sensitivity of the organism indicates that the factors in the host are as important as the type and efficiency of the anti-microbial agent.

contact whatsoever with surgical patients.

The University Hospital at Saskatoon was first opened to receive patients in January 1955, and a few serious staphylococcal infections appeared quite early on the surgical wards. It was apparent, therefore, that vigorous combative measures had to be introduced. This was agreed to and advocated by the medical and nursing staff. Initially, an isolation area consisting of one wing of 12 beds was set aside. Into this were transferred all patients who developed any infection in wounds, who were admitted with a discharging wound, sore or ulcer, or who were found to have staphylococci in their sputum or urine. There were individual rooms in this isolation area. No one was allowed to enter this area unless he washed, gowned and masked. He had to wash his hands again before leaving the area. As far as possible a separate nursing staff was used in this area. Housekeeping staff, physiotherapists, and all people, including visitors, who entered the isolation area, had to follow this regime. Visitors were limited to two per day.

This isolation area acted as an excellent training ground for teaching all members of the health team the discipline of isolation. But it was not entirely satisfactory because: (1) The patients did not like being moved to this area. They felt cut off and lonely, and they felt they were branded with some foul pestilence; (2) The doctors tended to neglect their patients once they were transferred into the isolation wing; (3) The nursing staff did not like it because the work was arduous, exacting and rather nerve-racking. They had difficulty making medical staff and patients observe the rules. As a result, there was a high turnover of nurses in this area.

After six months' operation the isolation wing was disbanded, and unit isolation on the separate surgical wings was instituted. But the area had done its work. It had made the staff, patients and visitors infection conscious, and had taught them the rules.

The surgical wards are fortunate in having an adequate number of single rooms with wash basins and toilets attached—a condition which enables all infected patients to be admitted to an isolation room, or transferred

On the surgical wards

Eric M. Nanson, F.R.C.S.*

SOME eighty years ago a revolution began in the surgical wards of hospitals. Previous to this pus had been laudable, it was the natural accompaniment of surgery. Then Louis Pasteur and Robert Koch announced their epoch-making discoveries of the nature and cause of infection. Joseph Lister was quick to appreciate the significance of the bacterial cause of infection, and so pus became no longer laudable but rather, lamentable. The Listerian era of antisepsis was born. This was quickly followed by the era of asepsis, pioneered by the work of Ignaz Semmelweiss in Austria, who showed the value of soap and boiling water in controlling "childbirth fever".

The year 1937 saw the development of the chemotherapeutic era as regards pyogenic infection, with the introduction of sulphanilamide, which was developed by the Germans from prontosil. Only five years later, in 1942, the discovery of penicillin by Fleming, and its commercial development by Florey, gave us the antibiotic era in which we now live. Each era was a tremendous step forward.

ward in the control of surgical infections and, with the advent of antibiotics, it was felt that the ultimate goal had been achieved in the prevention and control of these infections on the surgical wards. This has certainly proved true in connection with the less hardy organisms, such as the pneumococcus, the streptococcus and gonococcus; but one particularly hardy organism has remained, which has resisted the onslaught of the antibiotics—the staphylococcus. Hospital staphylococcal infection on the surgical wards has remained a problem, and in some areas has reached epidemic proportions. To tackle the problem, it was evident we would have to go back to the well-tried and proved principles of the pre-sulphonamides era—the principles of strict aseptic techniques and isolation procedures. We would have to regard staphylococcal infection as a serious menace to all surgical patients, and one which has to be constantly attacked by the whole staff who work on the surgical wards and in the operating rooms. The staff consists of the consultant surgeon, the resident staff, the students, the nurses, the dietitians, the physiotherapists, the housekeeping staff, visitors, and indeed, everyone who has any

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to one, if they are not already in a single room. The rule that any surgical patient who has a discharging wound, ulcer, sinus, or any suspected infection, who is developing a boil, or who has discharge around a drain, be placed in isolation by either the nursing staff or the resident staff is enforced. The consultant staff has no say in this and the procedure is backed up by the authority of the chief of surgery.

A bacterial culture swab is taken of the discharge and sent to the laboratory. A report on the type of the organisms and their sensitivities is usually back in 48 hours. If staphylococci are not present the patient is taken out of isolation. If the report is positive for staphylococci, then isolation technique is maintained until either a negative swab is obtained or the patient leaves hospital. The consultant in charge of the case is not allowed to order the patient out of isolation until the bacterial swab comes back negative.

Meanwhile, strict, acceptable,

and universally approved aseptic isolation is carried out. The patient has to remain confined to his room where he has his own toilet and wash basin. Everyone who handles him, or his bed, or anything he has handled, has to wash, mask, and gown. This particularly applies in bed-making, washing the patient, dressing his wound, and cleaning up his meal trays. Particular care in washing the hands after caring for the patient is taken. No hand antisepsics are used, as soap and water are thought to be adequate. Visitors are limited to two per day, and the door to the patient's room is prominently labelled "isolation". An "isolation cart" containing gowns, masks, laundry bags and hooks to hang coats on, stands outside his door. The nature of the infection and the necessity for isolation are carefully explained to the patient, stressing that the protection of the non-infected patient is vital. This fact the patient can appreciate and co-operates willingly.

The greatest difficulty in main-

taining the isolation disciplines is caused by consultant staff. The pervading feeling is that it is a disgrace that one of their patients should have an infected wound. At other times they just slip in to say "hello" to the patient and then can't resist having a "peek" at the wound. Therefore this matter of isolation discipline has to be brought up constantly at staff meetings and at times individual staff members may have to be reprimanded by the chief of surgery.

A constant check is kept by the chief resident on the number of infections occurring in the surgical wards. All infections, no matter how minor, are recorded monthly on a report form (Fig. I). This report is discussed each month at the surgical staff meeting, and copies are sent to the medical administrator of the hospital for referral to the Continuing Committee on Infections. No matter how minor, every infection is reported. Thus any discharge around a drain which may have been placed purely prophylact-

Fig. I

Department of Surgery

Infections:		Sepsis Report		May, 1957
A. Admitted with Infection:				
No. 15689	Cholecystitis	Peritoneal cavity	B. Coli	Dr. S.
15690	Infected Hip Nailing	Wound	Staph.	Dr. T.
15691	Incisional Hernia	Urine	Staph.	Dr. U.
15692	Frozen Fingers	Fingers	Staph.	Dr. U.
B. Developed Incidental Infection During Hospital Stay:				
No. 15693	Appendicitis	General	Chicken Pox	Dr. V.
15694	Perthes	General	Chicken Pox	Dr. T.
15695	Cong Disloc. Hip	Skin	Staph.	Dr. W.
C. Post-operative Infection:				
I. Major				
No. 15696	Gastric Haemorrhage	Incision	Staph.	Dr. X.
15697	Coarctation	Incision	Staph.	Dr. S.
15698	Cholecystectomy	Incision	Staph.	Dr. U.
15699	Appendicitis	Wound	B. Coli	Dr. V.
II. Minor				
No. 15700	Incisional Hernia	Wound	Staph.	Dr. U.
15701	Ca. Stomach	Drain site	Strep. B. Coli	Dr. U.
Incidence:				
Admitted with infection	4	4/238	1.7
Incidental	3	3/238	1.26
Post-op. Major	4			
Minor	2			
Total	—			
Carry over	4			
Total treated	17	13/238	5.5
Surgical infection per operation		6/217	2.75

ically is recorded, even though there is no cellulitis around the area, no fever, no evidence, in other words, of invasive infection. The reason for this is that it is necessary to know the monthly reservoir of infection. Furthermore, when a patient comes out of isolation, the room and all it contains is sterilized by fumigation. In this way the reservoir is kept down to a minimum. If this ruthlessly honest reporting of infections and rigid enforcement of isolation technique is not carried out, the reservoir may reach dangerously high levels and an explosive epidemic may arise.

The dressing of all wounds of all patients on the surgical wards, whether the patients are on isolation technique or not, is done from individual dressing trays. These trays are supplied by central sterile supply where they are autoclaved. Soiled dressings are placed in impervious paper bags and conveyed straight down to an incinerator and burned so that cross infection by poor dressing technique is avoided. The greatest danger is the transfer of staphylococci onto the hands of the dresser. With serious infections which are heavily conta-

minated, the dresser uses sterile rubber gloves to protect his hands from becoming contaminated. Dressings are done by a no-touch technique, using only forceps.

The evidence that these measures have proved effective is shown by the accompanying chart (Fig. II) in which the monthly infection rates are recorded over the past year. It is to be noted that the two important figures are: (1) The number of infections developing in hospital—*i.e.*, those presumably due to cross infection; and (2) the operation wound infection rate.

It should be pointed out that this latter rate may appear rather high, but it must be borne in mind that the criteria of what is called an infection are very stringent.

The types of cases which are placed in isolation and most commonly found on the surgical wards are: boils; carbuncles; burns; phlebitic ulcers; ischaemic gangrene of limbs; chronic osteomyelitis; staphylococcal infection in sputum; staphylococcal cystitis; and infected abdominal wounds.

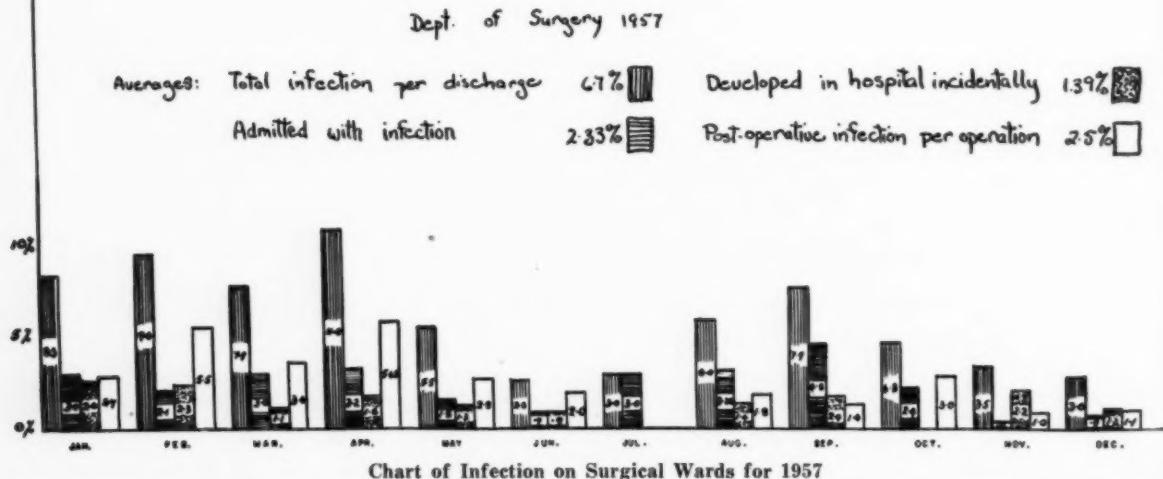
Boils and carbuncles deserve special mention because these obviously represent an invasive form

of organism, whereas staphylococci in sputum and urine may be merely transitory inhabitants without invasive properties. Therefore such staphylococci as found in boils require special precautions. Rubber gloves are worn in handling these patients to protect the staff from developing similar infections on their own skin, particularly on their forearms and hands. Burns are practically always infected and, because of the large surface involved, represent a large reservoir of infection, and therefore special precautions are again needed.

Staphylococcal infection on the surgical wards of the University Hospital, Saskatoon, has been kept under control so far. This has been achieved by rigid discipline and adherence to the principles of asepsis and isolation technique. The greatest difficulty lies with the discipline of the medical staff. It is essential that all the surgeons agree on the necessity for these measures, and co-operate with enthusiasm in helping to enforce them.

The aim is to keep the reservoir of infection down to such a low level that it is impossible for an annihilating epidemic to arise.

Fig. II
INFECTION RATES PER MONTH
Dept. of Surgery 1957



The total number of new infected cases, cases admitted with infection, and cases which develop infection incidentally while on the ward (*i.e.* cross infection) is recorded as percentages of the number of cases discharged for the month.

The number of cases who develop infection as a result of operation is recorded as percentages of the number of operations performed.

L'Accréditation des Hôpitaux

“La récompense en vaut la peine”

CES deux dernières années, j'ai eu le privilège d'être intéressé de près à l'accréditation des hôpitaux, tant comme représentant de l'Association des Hôpitaux Américains à la Commission Mixte de l'Accréditation des Hôpitaux qu'en qualité de représentant de l'Association des Hôpitaux du Canada à la Commission Canadienne de l'Accréditation des Hôpitaux. J'ai même eu l'honneur discutable d'être trésorier de ce dernier organisme — situation qui comportait bon nombre de problèmes ces derniers mois.

Tout cela m'a permis de constater que les membres de la Commission et les fonctionnaires chargés du programme d'accréditation ne cessent de lutter pour obtenir que les malades de nos hôpitaux bénéficient des meilleurs soins. De nos jours il n'est pas toujours facile de résister au pouvoir de la critique ni aux questions de ceux qui contestent la valeur des standards établis dans le but de les faire modifier ou rabaisser. Le prestige du programme vient principalement de ces hauts standards qui ont été fixés et conservés. L'accréditation des hôpitaux n'a jamais été une solution de facilité. J'espère qu'il en sera de même par la suite.

J'ai maintes fois entendu objecter que les médecins, qui représentent diverses organisations médicales et forment la majorité de la Commission Canadienne comme de la Commission Mixte, essaient de dominer la politique des Commissions, et cherchent même à les contrôler. Mon expérience me fait réfuter vigoureusement ces critiques. En réalité, à toutes les réunions de Commission, j'ai constaté

J. B. Neilson, M.D.*

de la part des représentants médicaux comme de celle des représentants hospitaliers, un sincère effort de collaboration au développement et à la mise en oeuvre du meilleur programme et, autant que possible, à l'amélioration constante de la qualité des soins hospitaliers.

Feu le Dr. Malcolm MacEachern a apporté au domaine hospitalier de nombreuses réalisations importantes et durables. Ce n'est pas le moindre de ses mérites que d'avoir été le premier à travailler à l'établissement des standards originaux que le Collège Américain des Chirurgiens adopta et fit connaître. Il mérite d'être noté, je pense, qu'un groupe organisé de chirurgiens fut le premier à reconnaître le besoin de standards hospitaliers d'un genre quelconque. Sous l'égide du Collège Américain des Chirurgiens et la direction active du Dr. MacEachern, la portée et l'importance du programme n'ont cessé de croître. Même des hôpitaux canadiens se virent accorder le droit d'être examinés et accrédités, bien que nulle aide financière directe ne provint de source Canadienne.

En 1952 il devint évident que les ressources du Collège Américain des Chirurgiens ne suffiraient pas à financer le programme, et le Collège annonça son intention de l'abandonner s'il ne pouvait obtenir quelque assistance. La valeur éprouvée du programme (maintenant connu sous le nom d' "accré-

ditation") suffit à réunir tous les intéressés dans une même volonté de continuation. C'est alors que fut créée la Commission Mixte d'Accréditation ayant son siège à Chicago. Y étaient représentés le Collège Américain des Chirurgiens, l'Association des Hôpitaux Américains, et l'Association Médicale Américaine. Toutes ces organisations acceptèrent de contribuer au financement du programme d'accréditation et chacune d'elles se vit attribuer un certain nombre de sièges à la Commission. Une fois organisée, la Commission Mixte offrit une participation à l'Association Médicale Canadienne. Cette offre fut acceptée et l'association Médicale Canadienne dispose maintenant d'un siège à la Commission.

Peu après la création de la Commission Mixte, les Cercles médicaux et hospitaliers Canadiens entamèrent d'importantes discussions sur les voies et moyens d'améliorer le programme d'accréditation au Canada. Ces discussions aboutirent à une proposition de création d'une Commission Canadienne d'Accréditation des Hôpitaux qui serait chargée de promouvoir l'accréditation et de l'adapter aux hôpitaux du Canada. Cette organisation, née en 1953, est formée de représentants des groupes intéressés et financée par les cotisations annuelles de ces groupes comme indiqué au Tableau I.

La Commission Canadienne a 12 membres dont les cotisations ali-

Tableau I

Organisations	Nombre de représentants à la Commission	Cotisation Annuelle
Association de Hôpitaux du Canada	5	\$12,500
Association Médicale Canadienne	4	\$10,000
Collège Royal des Médecins et Chirurgiens du Canada	2	\$ 5,000
Association des Médecins de langue française du Canada	1	\$ 2,500
	12	\$30,000

*Le Dr. Neilson a fourni cet article au congrès de l'Association des Hôpitaux de l'Ontario en octobre 1957. Il était alors surintendant des Hôpitaux Généraux de Hamilton, à Hamilton, Ont. Il est maintenant directeur des Services Hospitaliers à la Commission Ontario des Services d'Hôpitaux, "Ontario Hospital Services Commission".

mentent son budget annuel de 30,000 dollars. Elle nomme un président et a eu l'habitude de tenir deux réunions par an à Toronto.

Le but primordial de la Commission Canadienne a été de promouvoir et améliorer le programme d'accréditation au Canada. Pour ce faire la Commission a adopté les standards utilisés par la Commission Mixte mais nomme et emploie ses propres inspecteurs d'hôpitaux. La Commission Mixte continue à faire visiter des hôpitaux canadiens par des inspecteurs nommés par l'Association Américaine des Hôpitaux. Pour donner une idée de l'activité de la Commission Canadienne il serait peut-être utile de citer quelques chiffres. Le plan prévoyait la visite de 146 hôpitaux du Canada au cours de 1957. De ce nombre, 102 devaient être visités par des inspecteurs travaillant pour la Commission Canadienne, et les 44 autres par des inspecteurs de la Commission Mixte.

D'après l'accord en vigueur, la répartition des hôpitaux Canadiens à visiter est faite par la Commission Mixte, du fait qu'actuellement elle constitue le seul organisme d'accréditation reconnu. En conséquence, tous les rapports de visite sont adressés à la Commission Mixte, qui fait connaître les résultats et distribue les certificats.

Dès les débuts de la Commission Canadienne, nous eûmes la chance d'obtenir les services du docteur K. E. Hollis de Toronto, en qualité de directeur. Une grande part de l'importance prise par la Commission, tant en ce qui concerne sa réputation que son activité, est due à son travail exceptionnel. Au cours de ces derniers mois, le docteur Hollis a dû restreindre son activité et il a résigné ses fonctions de directeur, mais il continue à travailler pour la Commission en qualité de visiteur. Le Dr. W. I. Taylor, ancienement de Peterborough, a heureusement bien voulu prendre sa suite comme directeur. Il est entré en fonctions le 1er Septembre 1957 et travaille à plein temps, nous sommes certains qu'il continuera à assumer la direction ferme que requièrent la Commission et son programme.

L'importance prise par la Commission Canadienne, et la preuve qu'elle était en mesure de pourvoir aux besoins des hôpitaux canadiens, ont fait naître la conviction qu'un programme d'accréditation utilisant uniquement des ressources canadiennes était réalisable. Les autres organisations participantes

avent déjà approuvé l'idée d'un programme entièrement canadien et, lors de son assemblée biennale de mai 1957, l'Association des Hôpitaux du Canada s'inscrivit également en faveur d'un programme entièrement Canadien.

En conséquence, il a été décidé de préparer les débuts d'un programme entièrement Canadien pour le 1er janvier 1959 et la Commission envisage le projet avec enthousiasme. Bien qu'on ait avancé de nombreuses raisons en faveur du maintien de la coopération avec la Commission Mixte et que le programme entièrement canadien n'ait pas encore reçu une approbation unanime, il semble que ce soit là une évolution inévitable qui peut, à l'avoir des membres de la Commission, être envisagée en 1959.

Quelque deux années de pratique dans le domaine de la visite des hôpitaux canadiens, faite par des inspecteurs canadiens, nous ont permis une évaluation très satisfaisante des fonds nécessaires à la mise en oeuvre du programme, actuellement et pendant les trois prochaines années au moins. La Commission pense qu'en maintenant l'aide financière des organisations membres au niveau actuel, et en ajoutant à cela quelques fonds présentement disponibles sous la forme d'un petit surplus, un programme entièrement canadien et satisfaisant peut être mis en oeuvre en 1959 et 1960 sans qu'il faille réclamer des cotisations supplémentaires aux organisations membres. Personnellement, je suis persuadé que cela est possible.

Rémunération des Inspecteurs

L'un des problèmes majeurs posés par la mise en oeuvre d'un programme d'accréditation au Canada provient de l'importance des frais de déplacement nécessaires à la visite des hôpitaux à travers le pays. La Commission n'a cessé d'accorder une grande considération aux frais de déplacement et aux divers procédés utilisables. D'où la récente mise au point d'une nouvelle méthode de rémunération des inspecteurs. Les inspecteurs percevront pour la visite d'un hôpital une somme déterminée d'après la taille de l'hôpital. C'est là un système bien supérieur à celui du salaire, et il permet de recruter des inspecteurs dans diverses régions du Canada pour la visite des hôpitaux de leur propre secteur, ce qui réduit les dépenses exposées pour frais de déplacement. Cette méthode a été essayée avec beaucoup de succès et nous pensons que

son adoption contribuerait largement à satisfaire les besoins en inspecteurs d'hôpitaux et aiderait à résoudre l'un des problèmes financiers de la Commission.

Importance de la Tâche

En janvier 1957 il y avait au Canada 682 hôpitaux généraux et sanatoria pour tuberculeux de plus de 25 lits et par conséquent susceptibles d'être inspectés. Sur ce nombre, 351, soit 51 pour cent, avaient été visités par des inspecteurs et 292 hôpitaux, soit 43 pour cent, avaient été classés. C'est dans les provinces maritimes, où environ 70 pour cent des hôpitaux ont été inspectés, que le programme a obtenu le plus de succès. Il est évident qu'il reste encore beaucoup de chemin à faire si l'on veut parvenir au but final, qui est l'accréditation de tout hôpital canadien susceptible d'être accrédité. On a calculé que pour les trois prochaines années, le nombre d'inspections, initiales ou non, à faire par an au Canada sera de 130, dont probablement 20 inspections initiales. La Commission Canadienne devrait être à même de fonctionner sur cette base à partir de janvier 1959.

Dans la province d'Ontario, il y a actuellement 178 hôpitaux susceptibles d'être accrédités. Sur les 96 d'entre eux, soit 56 pour cent, qui ont été inspectés, 80 sont définitivement approuvés, 6 sont provisoirement approuvés et 10 ne sont pas approuvés. Au cours de 1957 on avait projeté l'inspection de 17 hôpitaux en Ontario.

A mon avis, nous devons reconnaître que dans notre province, où seulement 56 pour cent des hôpitaux susceptibles d'accréditation ont été inspectés, nous n'avons pas lieu d'être très fiers du résultat. En conséquence, il serait peut-être utile d'examiner quelques unes des raisons de cette situation et de chercher ce qu'on peut faire pour l'améliorer.

Bien rares doivent être ceux qui, dans le domaine hospitalier, n'ont pas conscience que l'accréditation est un objectif de grande valeur pour n'importe quel hôpital. Il n'y a pas de doute qu'avec toute la publicité faite au sujet de l'accréditation, quiconque veut de la documentation sur les conditions d'accréditation sait où l'obtenir. La Commission Canadienne d'Accréditation des Hôpitaux, 150 rue Saint George à Toronto, fournira cette documentation et se fera un plaisir d'aider tout hôpital qui le lui demandera.

(suite à la page 78)

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Operating Budgets

Under The Ontario Hospital Insurance Plan

THE federal-provincial hospital plan points to a stronger emphasis on operating budgets now than ever before. In Ontario, the hospital plan has created a widespread interest among the public because of the broad services and benefits which will be paid by the plan. But nothing in life is without cost, and so, in the future, hospital costs will have to be looked at closely to see how the benefits can be given under the funds available.

You may ask why the importance of operating budgets has been emphasized. It may help you to understand why if you realize that, in order to operate, hospitals must be paid their costs within a reasonable period after these costs have been incurred. The government-sponsored hospital insurance plans are committed to pay hospital costs; these costs are the expenses which are paid out by each hospital in providing services.

In order that they may be paid to hospitals currently, operating costs must be determined in advance, and a budget is the best means of estimating what the costs will be. Generally speaking, organizations which use budgets have found that planning in advance contributes to efficient operation, which, I am sure, is an ideal held by all hospital people.

The Ontario Hospital Insurance Plan comes into effect on January 1, 1959. As all hospitals are not fully familiar with the use of budgets, the Commission is asking every hospital to submit a budget for the year 1958. This will provide an opportunity to know the forms, to foresee problems, and to use the budgets for planning and cost control internally in 1958 as preparation for 1959.

The subject of hospital budgets is not a new one. The books and magazines which deal with hospital finances and administration

*Mr. McGavin, who is director of the Hospital Finance Branch, Ontario Hospital Services Commission, presented this paper at the annual convention of the Ontario Hospital Association in October, 1957.

E. P. McGAVIN, C.A.*
Toronto, Ont.

have contained, for years, articles and material on budgets. Last year, at this convention, R. M. Clements, accounting consultant with the Hospital Rate Board in Manitoba, presented to the accounting section an excellent paper on hospital budgets which was printed in the December 1956 issue of the *O.H.A. Accounting Bulletin* and you may find it helpful in preparing your 1958 budget.

Regional Conferences

Many of the hospitals in Ontario regularly draw up an annual budget, and they are familiar with the manner in which a budget is prepared, and how it is used from month to month throughout the year. There are other hospitals, of course, that are not familiar with budget planning control, and so the Ontario Hospital Association and the Ontario Hospital Services Commission have arranged six regional conferences at central points in the province to help them.

The 1958 Budget

An operating budget for 1958 is to be submitted to the Commission as a "dry run" in preparation for the hospital insurance plan. The following is what the hospital will be asked to do:

Hospital accounting supervisors should attend the regional accounting conferences being held in their areas. These conferences are set up to help in budget preparation. Larger hospitals might send their controller, treasurer, or chief accountant; smaller hospitals may wish to have their administrator, auditor, and accountant attend. The discussions will be informal and there will be time to answer questions completely. In addition, it will be an opportunity for representatives of the Commission to become personally acquainted with the hospital people. We think the conferences will be very worthwhile.

If you have trouble in preparing your budget, write to the

Commission, which will have one of its regional representatives from the Hospital Finance Branch visit your hospital to discuss the problem.

The budget should be used internally. When the budget has been finalized and approved by your hospital board, the information should be used to see how each month's actual expenditures compare with the budget. The accountant should provide each department head with a statement showing the actual departmental expenditures in comparison with the budget. When expenditures in departments exceed the budget, the administrator may require the department head to review the expenditures with him to justify them. It is also suggested that the monthly operating figures submitted to the hospital's board of directors should show not only the actual figures for the month and the year to date, but also the amount budgeted.

In 1958 the Commission will ask you to complete and mail in monthly a brief statement giving the highlights of your operating figures. In this way, the Commission can know how actual operations compare from month to month with your budget.

In turn, this is what the Commission will do:

The budget forms mailed to your hospital have been laid out carefully to tie in with your accounting records. The preparation of these forms is additional work for your business office, but it will bring its reward, for anyone who has prepared a budget has never regretted it.

A copy of the sample budget, also mailed to the hospitals, is set up on the budget forms so that each hospital will have a guide in preparing the budget.

Representatives of the Commission's Hospital Finance Branch will attend each of the regional conferences to assist with the budget papers, and to discuss the sample budget.

When the completed budget is received by the Commission, it
(continued on page 56)



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(continued from page 54)

will be analyzed and reviewed by the staff of the Hospital Finance Branch. These men are known as regional representatives and each one will be assigned to a number of hospitals.

During 1958 they will visit your hospital to discuss your budget and to become familiar with your costs operation. When they return they will discuss the points which have arisen during their visit with the Commission's group, and they will then make recommendations to the Hospital Rate Board on the acceptance or amendment of your budget. The Hospital Rate Board is an internal committee of the Commission, defined in the regulations.

Allowances

With the hospital insurance plan ahead of us, some hospital people will wonder what extra items that the hospital could not previously finance will be allowed in the budget. As a general rule, it is expected that every hospital, in preparing its 1958 budget, will do so in the same conscientious manner as it has done in the past. I am sure that even in hospitals which have not had a budget, the expenditure of hospital funds has always been carefully considered by the board and administration.

We all know that every year there are certain costs which increase to some extent and that

there may be other costs one year which do not recur the following year. The people on the Rate Board of the Commission have considerable knowledge of hospital and business operations and they will recognize in hospital budgets the expenditures which a reasonable and prudent person finds it necessary to pay. No doubt, they will also note any unusual increases and will expect that the reasons for such changes will be furnished in the explanation sheets. However, any expenditure which would contribute to good patient care would receive careful consideration.

The budget forms have been set up from samples which were prepared in 1956 by the accounting section of the Ontario Hospital Association. In preparing your budget actual expenditures for 1956 are to be set down. Then the actual expenditures for the first nine months of 1957 are taken after the trial balance has been balanced, and the 1957 expenditures are then projected to December 31. With the 1956 and 1957 figures now on the budget forms, a pretty fair estimate of what the expenditures will be in 1958 can be made. Hospitals will, of course, take into consideration all the variable factors they know in their costs.

There are supporting schedules on which the salaries and other

expenses are to be further detailed by departments.

The Hospital Fund

When the plan commences in 1959, the payments to the hospitals and of the Commission's administration expense will be made from the hospitalization fund. This fund will consist of monies which the Commission will receive from three sources—the province of Ontario, the federal government, and premiums paid by the public. As the hospital insurance plan should be of considerable benefit to the hospitals in Ontario, they will be interested to see that the hospitalization fund is kept on a sound basis. This can be done if increases in hospital budgets are kept on a reasonable basis. No hospital should consider the beginning of hospital insurance as an opportunity to obtain luxuries or make expenditures which previously were not necessary. I am sure that accountants, administrators, department supervisors, and members of hospital boards will continue, as in the past, to be careful of expenditures.

Specific Expenditures

What the policy of the Commission is on certain items of costs is explained under the following headings.

Depreciation

Under the arrangements between the provincial and federal governments, the hospital insurance plans in 1959 will pay the hospitals for depreciation on equipment, but not on buildings. This means that the accounting records on equipment of each hospital will have to be set up so that it is possible to see what equipment is fully depreciated at January 1, 1959, and what equipment is partially depreciated.

Capital Expenditure

A number of hospitals have asked what expenditures would be classified as buildings and what as equipment. As the federal government contributes to depreciation on equipment under the cost-sharing agreement, there will have to be agreement between the federal and provincial people as to what is a building expenditure and what is an equipment expenditure. The Commission expects to discuss this soon with Ottawa, when a check list will be issued, classifying each item of capital expenditures into groups

(continued on page 82)

Post-graduate Course in

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Applications are now being considered for the 1958-60 class in hospital administration which begins on September 15th of this year. Applicants must hold a baccalaureate degree, with acceptable academic standing, from an approved university.

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◀ Provincial Notes ▶

British Columbia

Prince George General Hospital is scheduled for completion in 1959. The five-storey structure will provide accommodation for 125 beds immediately, and allow for later expansion to 165 beds. A 54-bed nurses' residence will be built separately. Architects for the \$2,300,000 project are Berwick and Pratt, Vancouver. The hospital board has been considering the inquiries of English nurses who are interested in working at the new hospital as a possible answer to the nursing shortage.

Work drawings for a 90-bed hospital at Fort St. John have been prepared by architects Gardiner, Thornton, Gathe and Associates of Vancouver. The first by-law, to raise \$250,000 as the district's share, was turned down by the ratepayers. A new by-law will be presented.

Maple Ridge Hospital has received a cheque for \$2,300 from the Haney Rotary Club. The new hospital will soon be completed.

Tenders have been called for the new general hospital at Kitimat. Construction is planned in two stages, the first to provide 113 beds with services for a 200-bed institution. Semi-finished areas will be constructed to permit expansion to 145 beds. A three-storey medical arts building, also to be built by the Kitimat Hospital Society, will be joined to the hospital by corridors. Architects are Berwick and Pratt, Vancouver.

A traction frame for treatment of fractures and hip dislocations in children has been presented to Kootenay Lake General Hospital by Soroptimist International of Nelson. A \$950 electrocardiograph was donated by the Kiwanis Club.

Plans for a nurses' residence for Tofino General Hospital have been completed by architects Whittaker and Wagg, Victoria.

Commencement date for construction of the new \$1,500,000 patients' wing and administration block at Royal Jubilee Hospital, Victoria, has been delayed until 1959. A cancer clinic, to house a cobalt bomb, is also planned for the hospital.

Salmon Arm district has approved a \$712,000 50-bed hospital to serve the Shuswap Lake area.

Alberta

The first group of patients have been admitted into Deerhome Mental Institute at Red Deer. The heating plant, laundry, kitchen, bakery, water tower, nurses' residence, and two of the eight dormitories planned have been completed. The third dormitory is well under construction. In five years, when the project has been completed, the Institute will house 1,200 patients.

The proposed extension to the Hanna Municipal Hospital and renovation of the present building will cost \$165,000. The extension will have two floors and a full-sized basement.

Graduate nurses of Medicine Hat Municipal Hospital have presented the chapel of the new hospital with a cross and candlesticks. The nurses established the chapel fund rather than exchange gifts at Christmas.

The new Wetoka Health Unit building has been turned over to city officials of Wetaskiwin.

The \$350,000 extension to High River Municipal Hospital will provide administration offices, an obstetric wing, delivery rooms, surgical theatres and 20 additional beds. Architects for the three-storey structure are A. Dale and Associates, Vancouver.

Plans for a 20-bed hospital and nurses' residence have been drawn for the Bow Island Hospital Board by architects McKernan and Bouey, Edmonton.

Saskatchewan

Tenders have been called for a new 10-bed hospital at Dinsmore. Plans for the frame and stucco building were drawn up by architects Webster and Gilbert, Saskatoon.

The North Central Regional Council of Hospitals has approved a budget of \$46,000 for 1958, and returned Mrs. Marion Sherman as council chairman. Six of the 17 member hospitals are planning construction.

Manitoba

Victoria General Hospital, Winnipeg, has received \$7,500 for repairs and new equipment, and the Children's Hospital and Winnipeg General received grants of \$5,000 each for new furnishings and equipment from the Winnipeg Foundation.

Dishes will no longer be washed by hand at the Swan River Valley Hospital. The new dishwasher, installed at a cost of \$1,700, heats the water as well as washing and rinsing dishes and cooking utensils.

On the occasion of their 45th wedding anniversary, Mr. and Mrs. H. Kay, Winnipeg, donated \$1,000 to the Children's Hospital for research. By contributing anniversary gifts to this fund, friends have more than doubled the original contribution.

Ontario

A network of pipelines has been installed in St. Joseph's Hospital, Hamilton, to carry oxygen to the bed of each patient. A bank of reserve cylinders in the central, outside unit will automatically start feeding the system in an emergency.

The new addition to Ajax and Pickering General Hospital will increase its present accommodation from 37 to 49 beds. The \$50,000 extension is regarded as a stop-gap until a larger hospital can be built and present facilities used as an out-patient department.

St. Mary's Memorial Hospital has received a \$2,000 donation from a local firm.

The Credit Valley Lions Club has presented the South Peel Hospital Board with a check for \$15,000 of the \$25,000 the club has pledged to the new hospital to be opened in April.

The 50th anniversary of x-ray at Victoria Hospital, London, coincided with the 21st annual meeting of the Canadian Association of Radiologists held there.

Completion of the new 48-bed addition to the Alexandra Marine and General Hospital, Goderich, was marked by an open house.

Ottawa Civic Hospital has received a bequest of \$10,000 in the will of the late E. Norman Smith, for many years a trustee and chairman of the board. The legacy is to be used for "the comfort, entertainment, and advantage" of student nurses.

(concluded on page 90)

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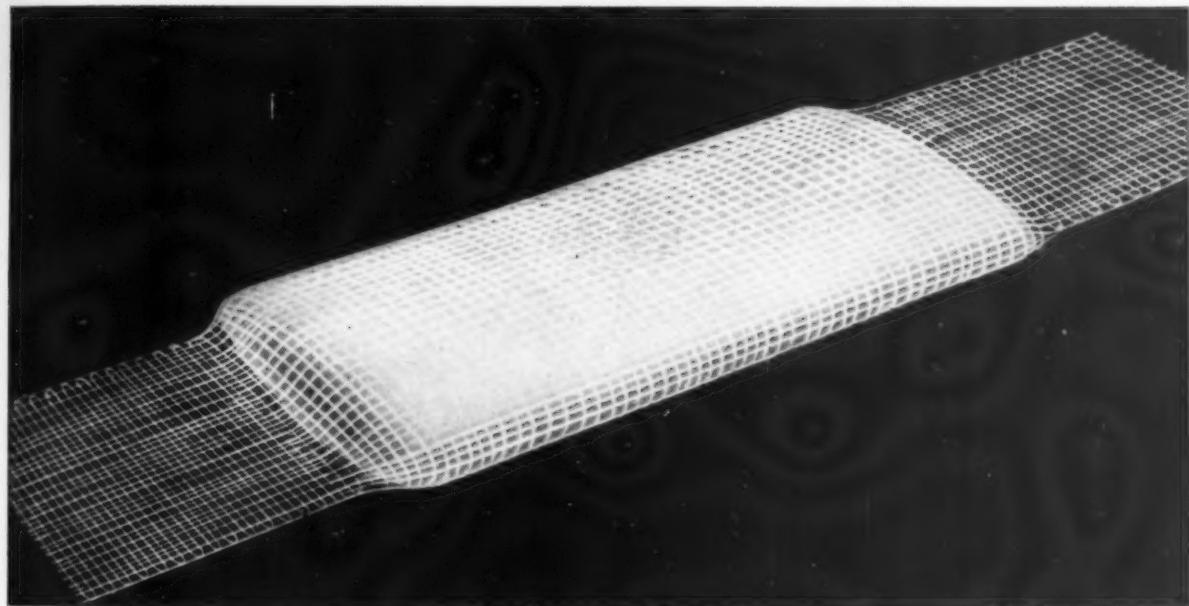
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With the Auxiliaries

Meeting Increased Demands

Hospital auxiliaries must keep aware of changing problems and needs of their hospitals in order to best serve their current needs, said Mrs. J. J. Block, president, at the annual meeting of the Women's Auxiliary of the Jewish General Hospital, Montreal, Que. A survey committee has been formed in this auxiliary, charged with the responsibility of studying its administrative structure and functional organization and of making recommendations for improving that structure and the efficiency of the group. In addition, Mrs. Block recommended that the survey committee form a planning section responsible for a continuous survey of the hospital's current needs and construction requirements in the future.

A new policy of establishing branch units of the auxiliary in suburban districts has been undertaken. The first branch, in Côte St. Luc Village, held its initial meeting in January. A volunteer department has been established in the hospital with a full-time director paid by the auxiliary. Organized just 18 months ago, this department has logged 1,257 hours of work at as many as 42 different assignments for one month, exclusive of the work done in the canteen.

"There is just no substitute for human kindness and a helping hand," said Mrs. Block, "and in some instances, volunteer workers can release highly trained personnel for more specialized duties. There is so much to be done for so many people that more volunteer workers will be needed."

Stars Light, Stars Bright

Stars twinkled from myriad mobiles in the ballroom of the Royal York Hotel, Toronto, Ont., on the evening of the ball held annually by the Women's Auxiliary of the New Mount Sinai Hospital. In the foyer over 1,200 guests were greeted by bouquets of star-spangled branches, and by smiling young women who presented each lady with a gift and each gentleman with a buttoniere. In the ballroom were fairy princesses, garlands of blue tinsel, branches of stars and winking blue lights.

Winners of the Starlight Draw were awarded two holiday weeks in Ochos Rios, Jamaica. Sale of tickets for the ball amounted to over \$14,000. The proceeds will contribute to the hospital's Free Care program.

Home Tartan Best

Keltic Cookbooks have brought in \$647.06 to the Women's Auxiliary of St. Martha's Hospital, Antigonish, Nova Scotia. There is still a limited number of the books available. The auxiliary also makes and sells "Highland Lassie" dolls. In the past the dolls were dressed in any of the various tartans, but the Nova Scotian tartan seems to be so much preferred that this tartan will be used for most of the dolls in the future. The auxiliary will raffle a large doll for the district's Highland Games.

Visitors' Control Service

A Visitors' Information Service has been set up as a volunteer project by the Women's Auxiliary of the Groves Memorial Community Hospital, Fergus, Ontario. Time is proving to the Fergus hospital that it benefits the patients and aids nursing care to have control of visiting. Many hospitals have enquired about the system, and several have set up their own Visitors' Control Services manned by volunteers.

Bonspiel at the Bluenose

The annual bonspiel in January is the major project of the Ladies' Auxiliary to the Aberdeen Hospital, New Glasgow, Nova Scotia. Held at the Bluenose Rink, the bonspiel featured an afternoon tea and pantry sale on the second day of play, besides three days of curling. Prizes were awarded for various projects during the bonspiel as well as for the final winner.

A Year's Work

Highlight of the annual meeting of the Women's Auxiliary of Toronto General Hospital and the Wellesley Division was the presentation of \$10,000 to the hospital for equipment and improvements. Of the amount, \$2,600 has been set aside for social service work; \$2,000 for the Clinical Investigation Grant; \$1,000 to a fund for special nurses for indigent patients; and \$1,000 for furniture for

the new rehabilitation centre. This donation represents a year's work in the W.A. shops in Toronto General and Wellesley hospitals.

The Women's Auxiliary of Toronto East General was also able to present its hospital with a cheque for \$10,000. This brings to \$15,000 the auxiliary's contribution to the building fund.

"Hospital Day" Cards

"Hospital Day", May 12, the birthday of Florence Nightingale, gives the auxiliaries an opportunity to direct the attention of their communities to the hospitals and the work they are doing, and to say "thank you" to the many who have given help. The press and radio stations are generally willing to help; there are many merchants who would allow the auxiliary a window for a photograph display. Auxiliary members can speak to clubs. The hospital might hold an open house.

The National Council of Hospital Auxiliaries of Canada has prepared cards telling of the true implication of the day and of the part which the auxiliary plays in the hospital. The card might be placed on the patient's tray on Hospital Day as a gift from the auxiliary. The cost of the card is five cents, with an order minimum of 50 cards. Orders should reach Mrs. J. C. McDougall, 3156 Trafalgar Ave., Montreal, P.Q., not later than March 24. Any profit from sale of these cards will be applied to the Council's scholarship fund.

For the Veterans

A wheel chair and five electric shavers were presented to Shaughnessy Hospital, Vancouver, B.C., by the Ladies' Auxiliary to Army, Navy and Air Force Veterans Unit 100. This is the ninth wheel chair the group has presented to the hospital.

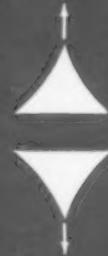
In St. John's, Newfoundland

In 1957 the Women's Auxiliary of Grace Hospital, St. John's, Newfoundland, furnished another children's ward. Since their organization in 1949 the ladies have raised \$23,902.58 for the hospital, by monthly projects, a Fall Sale, and Turkey Teas. Besides furnishing and equipping the children's wards, they have purchased an elevator for the nurses' residence, and installed a paging system in both the hospital and nurses' residence which broadcasts programs, music, and Christmas carols from the nurses' lecture hall directly to the

(concluded on page 96)

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Book Reviews

THE STORY OF THE FIRST THREE YEARS, by Lola Wilson, R.N. Prepared under the direction of The Steering Committee for the board of administration of The Centralized Teaching Program for Nursing Students in Saskatchewan, Canada, 1957. Pp. 80.

The close of 1955 witnessed the completion of the three-year experimental period of the Centralized Teaching Program for Nursing Students in Saskatchewan. Because of this venture's success, it has been possible to incorporate the program into the general nursing education program of the province. This small paper-backed booklet is the report of the experiment from its inception in 1953 to its completion in 1955. In it is recorded the information collected prior to the program's implementation, as well as a detailed description of the curriculum, staff, centres, financial arrangements and organization. Miss Wilson has summarized the problems the Saskatchewan system evoked and has cited its achievements. A concise and lucid picture of the pre-clinical teaching in the basic sciences of nursing undertaken by the Centralized Teaching Program is presented, and those interested in nursing education will be sure to find Saskatchewan's efforts in this field very worthwhile reading. Inquiries about the report might be directed to Miss Wilson, who is executive-secretary of the Saskatchewan Registered Nurses' Association, Regina, Sask.

THE STUDENT PHYSICIAN, edited by R. K. Merton, G. Reader, M.D., and Patricia L. Kendall. Published in Canada by S. J. Reginald Saunders, Toronto. Pp. 360. Price \$5.50.

The systematic inquiry of scientific research has been turned on the processes of medical education itself in this study of the sociological and psychological problems inherent in the development of a doctor. Its focus is on the ways in which the medical school and its social structure affect the medical man it produces.

Part I relates the social sciences to medicine. Not only can the doctor use the social sciences in practice of medicine, but the focus of sociological studies on medical

education itself can mean more economical distribution of the educator's talents and the students' time. It is up to the medical school to provide a "sufficiency" of incentives, so that students want to work but are not hindered from working by anxiety about it.

The papers which follow constitute the first set of reports on the sociology of medical education by the Bureau of Applied Social Research of Columbia University, in collaboration with the schools of medicine at Cornell, the University of Pennsylvania, and Western Reserve University. Part II discusses the decision to enter the medical profession and specialization within the field. Part III traces the student's change of attitude toward the powers and limits of medical knowledge as his own knowledge increases. Uncertainty is treated as a fact to be accepted as the doctor goes ahead and does what he can. Part IV outlines Cornell's comprehensive care and teaching program as a living experiment.

Notes on socialization, research in progress, and significance tests are provided in appendices. Also included is the questionnaire sent out to medical students on which much of the study is based.

This study points out to medical educators that they are responsible for the kind of doctors produced by their schools. Just as the patient is more than a disease entity, the medical student is more than a passive receptacle to be filled with information.

NURSING IN DISEASES OF THE EYE, EAR, NOSE AND THROAT, from the Manhattan Eye, Ear, Nose and Throat Hospital, New York, N.Y. Published by W. B. Saunders, Philadelphia, Penn. Illus. Pp. 269.

Constant change and advancement in the care and treatment of the eye, ear, nose and throat have made revision necessary for the tenth edition of this book. The content has been expanded or deleted to meet the requirements of modern treatment, and reorganized to segregate the principles and techniques of nursing care from medical treatment.

Part I is devoted entirely to the

eye. It outlines its anatomy and physiology, instruments used in examination, testing of vision, correction of errors, orthoptic training, external and internal diseases, various eye defects, nursing in surgery as well as in routine procedures, and ophthalmic therapeutics.

Part II is concerned with the ear, nose and throat. It discusses in each case the anatomy and physiology, methods and instruments used in examination, diseases, and nursing procedure in surgery. Also included are chapters on reconstructive surgery of the face, preparation of surgical dressings, and management of troublesome children.

Photographs and diagrams have been carefully integrated into the text to clarify each discussion. A full glossary is provided for each part. The principles of nursing care are restated as well as introduced at the beginning of each discussion of nursing procedures. This revised edition is primarily concerned with actual, nursing care.

SIMPLIFIED DIET MANUAL, prepared by the Nutrition Service of the Iowa State Department of Health, in co-operation with the Iowa Dietetic Association. Published by the Iowa State College Press, Ames, Iowa, U.S.A., 1958. Canadian distributors, Thomas Allen Limited, Toronto, Ont. Pp. 90. Price \$2.05.

Here is a handy little text with neatly catalogued charts and basic menus, approved by Iowa State's medical society, dietetic association, hospital association, and board of health. It is prepared primarily to guide physicians in prescribing modified diets, and for helping hospital personnel in interpreting dietary orders—especially in those hospitals where there is limited dietetic supervision. The manual's basic premise is that all diets should be nutritionally adequate, and with this thought in mind, menus geared to diets of low-sodium, bland, liquid, and low residue content, as well as ones for the ulcerated, diabetic and obese patients, are suggested.

Law of Use

The worth of exercise rests upon a basic principle: The Law of Use. The father of medicine, Hippocrates, the first to break away from the idea that disease is due to the anger of the gods, declared in the fourth century, B.C.: "That which is used develops and that which is not used wastes away."—*Monthly Letter, Royal Bank of Canada.*

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Notes on Federal Grants

Construction

Three federal grants totalling \$65,500 have been awarded to two Montreal, Que., hospitals. St. Mary's Hospital will receive two of them—one of \$25,500 will go towards alterations on the seventh floor of the east wing, where a 27-bed ward is planned to replace old personnel quarters. In the west wing an \$18,000 grant will help meet the costs of adding 18 beds to a 30-bed paediatric unit. These alterations to St. Mary's will increase patient beds from 258 to 303.

The Montreal General Hospital has been assigned \$22,000 of the sum for increasing the 248 beds in the nurses' residence by 44.

The construction of a community health centre at Grand Forks, B.C., will be assisted by a grant of \$6,400. This centre is to provide office space for two nurses and a sanitarian, and will also be equipped to house travelling clinics and voluntary health societies. The Gyro Club of Grand Forks organized the project, but the municipality will take over ownership on the centre's completion, scheduled for early this year.

The General Hospital at Stratford, Ont., will receive nearly \$5,700 for the addition of a "training area" for nurses.

Just over \$6,000 has been granted to the Civic Hospital at North Bay, Ont., to go towards the cost of constructing an area for three new active treatment beds and new laboratory facilities.

Nelson, B.C., is expected to have

its new 100-bed hospital operating by the end of 1958. The present building of the Kootenay Lake General Hospital is to be replaced by a completely new structure, begun last summer. Slightly more than \$136,000 has been granted for the costs of the reinforced concrete building. Planning allows for 30 bassinets and space for out-patient services as well as the 100 beds. A fourth floor can be added at a later date.

The Salvation Army Grace Hospital, Toronto, Ont., is expected to move into a new structure, double its present space, in the fall of 1958. Nearly \$125,000 has been granted to go towards the costs of the building, which was begun in the summer of 1957. An additional 83 beds and 88 bassinets, as well as facilities for medical and surgical patients are to be included in the new quarters. It is planned that the present building, containing 54 beds, be used as a nurses' residence after the move.

A grant of nearly \$69,000 has been assigned to go towards the construction costs of a nurses' residence for the Winnipeg Children's Hospital, Winnipeg, Man. The new building will accommodate 99 beds as well as four active treatment beds in the nurses' sick bay. Teaching facilities are to be given 4,555 square feet of the new structure.

The extension of the out-patient department of the Toronto Western Hospital, Toronto, Ont., will be assisted by a grant of slightly more than \$18,000. A one-storey

addition will add about 5,000 square feet to the present clinic.

An addition to the Saskatchewan Hospital, North Battleford, Sask., will be helped by a grant of \$170,000. A 120-bed building, scheduled for completion by the end of the present year, will raise the total accommodation to 1,913.

Public Health

A grant of \$4,130 will provide Souris District Hospital, Souris, Man., with the money for building laboratory and x-ray space. Two technicians are to be stationed here, and it is anticipated that persons in the southern end of the Virden unit will be able to have their work done in the closer Souris hospital.

Just over \$6,000 has been awarded to 27 Alberta nursing districts for electric sterilizers. The equipment will be used mainly for sterilizing materials used in health programs.

Health centres in Lemberg and Fox Valley, Sask., have been allotted more than \$5,400 in federal grants to help meet their construction costs. In Saskatchewan the solution of the problem of extending adequate health facilities to the more isolated areas is being sought through the building of small community health centres containing a doctor's office, x-ray and laboratory facilities, one or more emergency beds, offices for public health nurses and sanitarians, and space for such public health services as prenatal or immunization clinics, and a dental program.

The Lemberg centre, which receives about \$2,300, will be operated by the board of the Balcarres Union Hospital District, and the Fox Valley centre, with \$3,100 of the grant, by the Maple Creek Union Hospital board.

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EMOTIONS and the DIET

A. H. Squires, M.D.*

THAT emotion affects the physiology of the stomach and gastro-intestinal tract has long been appreciated. Over 100 years ago Beaumont recognized that changes in gastric function took place in people under emotional stress. The "subject" under observation at this time was Alexis St. Martin, who had a gastric fistula resulting from a gun shot wound. During emotional states such as fear and anxiety very definite changes in the appearance of gastric mucosa and in the secretion of gastric juice were observed. More recently, Wolfe and Wolfe, on their famous patient, "Tom", have demonstrated that emotions involving hostility, resentment and anxiety were accompanied by increased motility, secretion, and vascularity. Other feelings, fear, sadness and desire for withdrawal, were associated with a depression of gastric function. These experiments are of practical value since they set the pattern for the type of reaction seen in many emotional disorders.

We have all heard the expressions, "be happy and grow fat", and "the fat person is a merry one". Fat people then, we infer from such statements, must be content and satisfied. This may be true in some cases, but in others, it could not be more wrong!

About the time of the menopause a woman feels the years are closing in on her rapidly. Her husband is perhaps successful in his business, a situation that keeps him from giving his wife the full attention she craves; the children

are growing up and do not need or want the tender care of their mother. The result is that the mother, because of circumstances, feels alone, unwanted, and becomes resentful, even frustrated, and to compensate for these things takes solace from the ice box. She eats for satisfaction, but not because she is happy.

Take too, the case of a young woman, unmarried, longing to be loved, and to have a family and husband. Her tendency to be overweight, she feels, is a great handicap to her. She tries to diet and for a while successfully loses some weight. With any setback, however, and during times of stress, she reverts to her old habits and cheats on her diet. Such a person cannot be controlled by being given a pat on the back and an 800 or 1200 calorie diet. A much bigger problem lurks within herself. Of course, this problem may be insurmountable, but on the other hand, with understanding and guidance the problem may be recognized and conquered.

The first type cited is very common; her problem revolves about a situation, and therefore is difficult to handle, but with co-operation and understanding by all concerned she can be helped. The second case can be helped by encouraging her to focus less attention on soul-searching and diet. When she overcomes her obsession about her size she can face the world with confidence. Only then will she be able to regulate her eating habits.

Food Service

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Canadian Dietetic Association

Many young adolescents suffer the same emotional stress because they are overweight. They often, if not set on the right path early, lose all concern about their appearance. They are unhappy, but become hostile and resist all attempts to help them. These are the people who are hard to help.

Then, of course, there are the big, fat, jolly people who are perfectly happy being just that.

Fear and sadness have the opposite effect on gastric function. A person, during a state of emotional depression, loses interest in food. This may occur with both animals

or human beings after an emotional upset, such as the loss of a loved one. A feeling of hopelessness crowds out every thought. This feeling may also come with the knowledge of contracting an incurable disease. These "depressed" patients are referred to as "reactive", because their state is produced by a reaction to a problem or situation. These are the people who gradually withdraw within themselves and lose all interest in life. As they do, their whole metabolism becomes more and more sluggish. Although they may feel they want to eat, they become anorexic and the desire fades when the food is set before them. The result is a weight loss. The doctor may aggravate the situation by not recognizing that there is an emotional problem involved and looks for an organic cause—thus tending to increase the patient's fear. At the same time the basic problem which has produced the depression—fear and loss of appetite—is growing inside that patient. On the other hand, a high calorie diet may be ordered—and there is nothing more dispiriting than to see a plate piled high with food when you are not well. This, of course, is true with organic disease as well as with psychological disease. The result is that the patient takes one look at his plate, and pushes it aside. In mild cases of anxiety, fear and depression, sympathetic understanding and encouragement to face the problem, supported by mild sedation, are indicated. Insulin and an interesting, attractive, small diet will help this person eat and reverse the depression.

In the more severe depressions, when psychological therapy is of no help and the depression is not related to situation, shock therapy is of value.

There is one form of disturbance associated with anorexia where life is endangered. This is *anorexia nervosa*. The patient is almost always a female, unmarried and young. To observers at home she seems to eat nothing at all as far as they can judge. She wastes away until she has become a "bag of bones". The skin wrinkles, dries and loses its elasticity, and the patient has the appearance of end-stage malignancy or tuberculosis. The monthly periods are absent—a symptom which occurs early in the illness. Yet for a long time she retains her energy and can walk for long distances and engage in similar energy-consuming ac-

(continued on page 74)

*Dr. Squires is physician-in-chief at the Wellesley Division, Toronto General Hospital, Toronto, Ontario. He presented this paper at the dietetic section meeting at the 33rd convention of the Ontario Hospital Association, in October, 1957.

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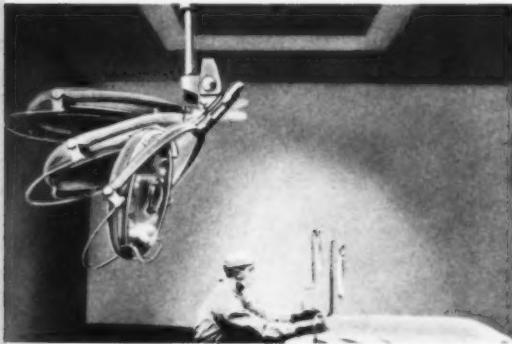
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Emotions and Diet

(continued from page 70)

tivities. She will not admit she is ill. There is no doubt from the beginning that she will get food surreptitiously. She may go to the dining room, eat a few crumbs and say she is not hungry. But then she will eat food she has taken from the ice box or hidden about the house. The amount taken is very small but she will be secretive about eating it. Eventually, after a long time, the patient will become bedridden and may die of a secondary infection.

It is hopeless to treat this patient except by isolation. She must be in bed, and must see no one except the nurse and doctor. She must have no communication with friends because she will complain and upset and confuse them. Feeding must be started very gradually for the stomach is in a condition where very little food can be tolerated. To start, the patient should not receive more than two ounces of milk every two hours. This is probably more than the patient

has been taking for a long time—less may be given. The important thing is that the patient must not be rushed or she will get frightened. The amount is gradually increased to double the amount of milk eight times a day. This is helpful but not enough to foster weight-gain. The stomach may react and food may stay there unchanged for hours or days, or the patient may vomit. If no unfavourable setbacks occur, solid food—bread, meat, fish, milk puddings, et cetera—are slowly added and there will be a steady gain in weight of four to five pounds a week. The patient is kept in bed and fed by the nurse, otherwise the patient will play with her food, or throw it away, pretending to have eaten it. It is essential for her to remain in bed until there is a gain of 20-30 pounds.

Why did this young person stop taking food? The solution is the same as with any other neuropathic state. It may be that she wished to be thin and overdid it. In many cases the mother is a domineering

type, and has nagged the girl about taking more food until it became a point of honour to take less. The mother may also be stoutish herself and the daughter will, all the more, wish to be thin. Every case needs its own investigation.

All illnesses may have a great, if sometimes temporary, psychological effect which the physician or dietitian will realize when they themselves become ill. In transient illness this is not important, but when the disease threatens life, social or economic position, hopes or ambitions, it becomes a matter of profound anxiety. It may manifest itself in many ways, but most common, are a feeling of complete exhaustion quite out of proportion to the illness, a loss of appetite and often anorexia.

The patient's conception of his disease and its course, taken with his basic personality, often determines his psychological reaction. In assessing these symptoms, it's important to discuss with the patient his conception of his illness, and to explain in careful detail what you feel is necessary in order to place the patient at ease and allay his fears. A doctor learns it is very difficult to explain to an anxious patient the nature of his disease, for the patient tends to take the unfavourable view. When a patient is afraid and disturbed, even though outwardly calm, he often misconstrues what the doctor says, or he may be so upset that he doesn't even understand what is said. Even highly intelligent people have to be told over and over again. Even though you may reassure the patient that he is going to be well soon, the next day he and his wife may think you said that he was near death.

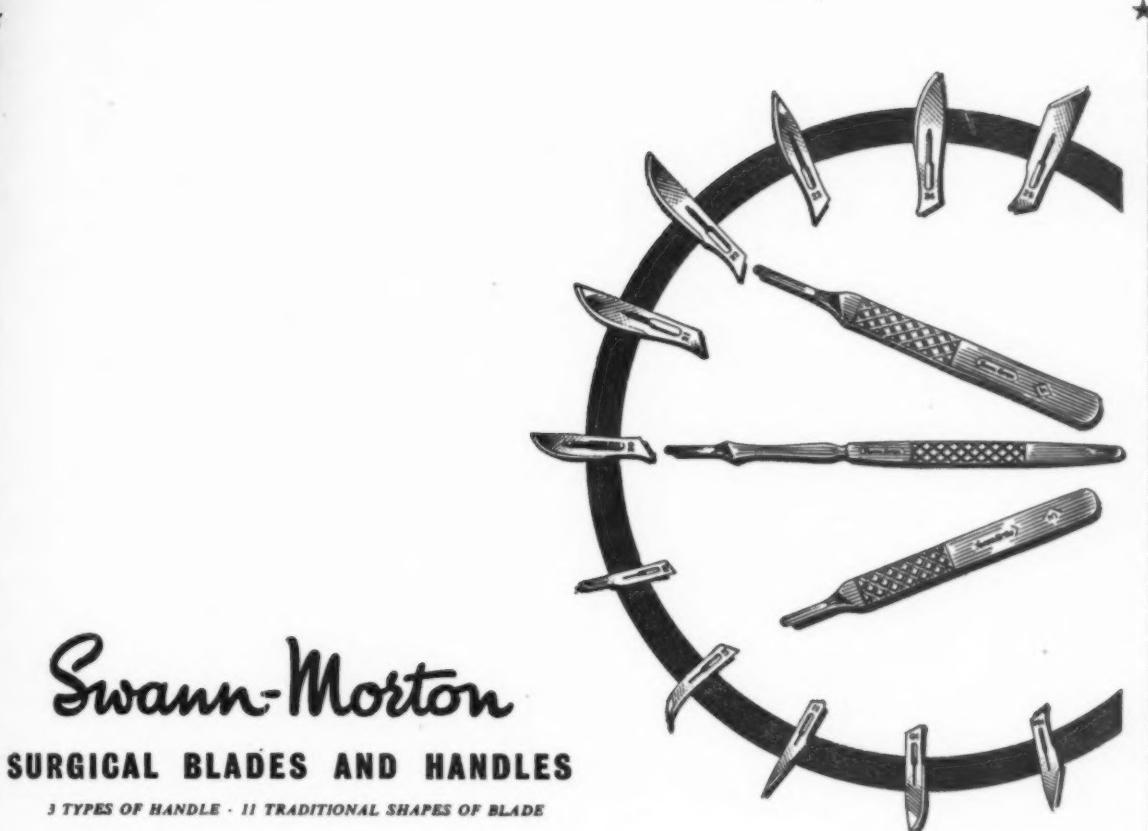
People react in different ways to the knowledge of a fatal illness. Some are stoical and can take it, some, like the group described above, become morbid, depressed, hostile, and disagreeable—the patients who develop the symptoms of anxiety with exhaustion, and loss of appetite.

The fear of incapacity is also a source of anxiety. If these people have minor arthritis, which is self-limiting in nature, they can only see themselves becoming hopeless invalids, and unless the doctor shows a sympathetic interest and can adequately reassure the patient, emotional degeneration will continue.

Anxiety will be aggravated by fear of new surroundings when the

Coming Conventions

- Apr. 14-16—College of General Practice of Canada, second annual scientific assembly, Royal Alexandra Hotel, Winnipeg, Man.
- Apr. 14-18—Eastern Canadian Regional Meeting, American College of Hospital Administrators, Mount Royal Hotel, Montreal, Quebec.
- May 25-26—Catholic Hospital Conference of Manitoba, annual meeting, Winnipeg, Man.
- June 3-6—The Maritime Hospital Association, annual meeting, Algonquin Hotel, St. Andrews, N.B.
- June 9-11—Canadian Dietetic Association, 23rd annual convention, Sheraton-Brock Hotel, Niagara Falls, Ont.
- June 12-14—Canadian Association of Physical Medicine and Rehabilitation, annual meeting, Quebec City, P.Q.
- June 16-20—Canadian Medical Association Convention, Nova Scotian Hotel, Halifax, N.S.
- June 17-20—16th annual convention of the Canadian Society of Radiological Technicians, Fort Garry Hotel, Winnipeg, Man.
- June 21-22—Conference of Catholic Schools of Nursing, annual meeting, Atlantic City, N.J.
- June 21-26—Catholic Hospital Association of the United States and Canada, annual convention, Atlantic City, N.J.
- June 23-27—Canadian Nurses' Association 50th Anniversary Meeting, Lansdowne Park, Ottawa, Ontario.
- June 25-27—Comité des Hôpitaux du Québec, annual convention and commercial and scientific exhibition, Montreal Show Mart, Montreal, P.Q.
- Aug. 18-21—American Hospital Association, annual convention, International Amphitheatre and Palmer House, Chicago, Ill.
- Oct. 15-17—The Saskatchewan Hospital Association, annual meeting and institute, Bessborough Hotel, Saskatoon, Sask.
- Oct. 21-23—Annual convention of the Associated Hospitals of Alberta, Jubilee Auditorium, Edmonton, Alta.
- Oct. 28-31—Annual convention of the B.C. Hospitals' Association, Hotel Vancouver, Vancouver, B.C.



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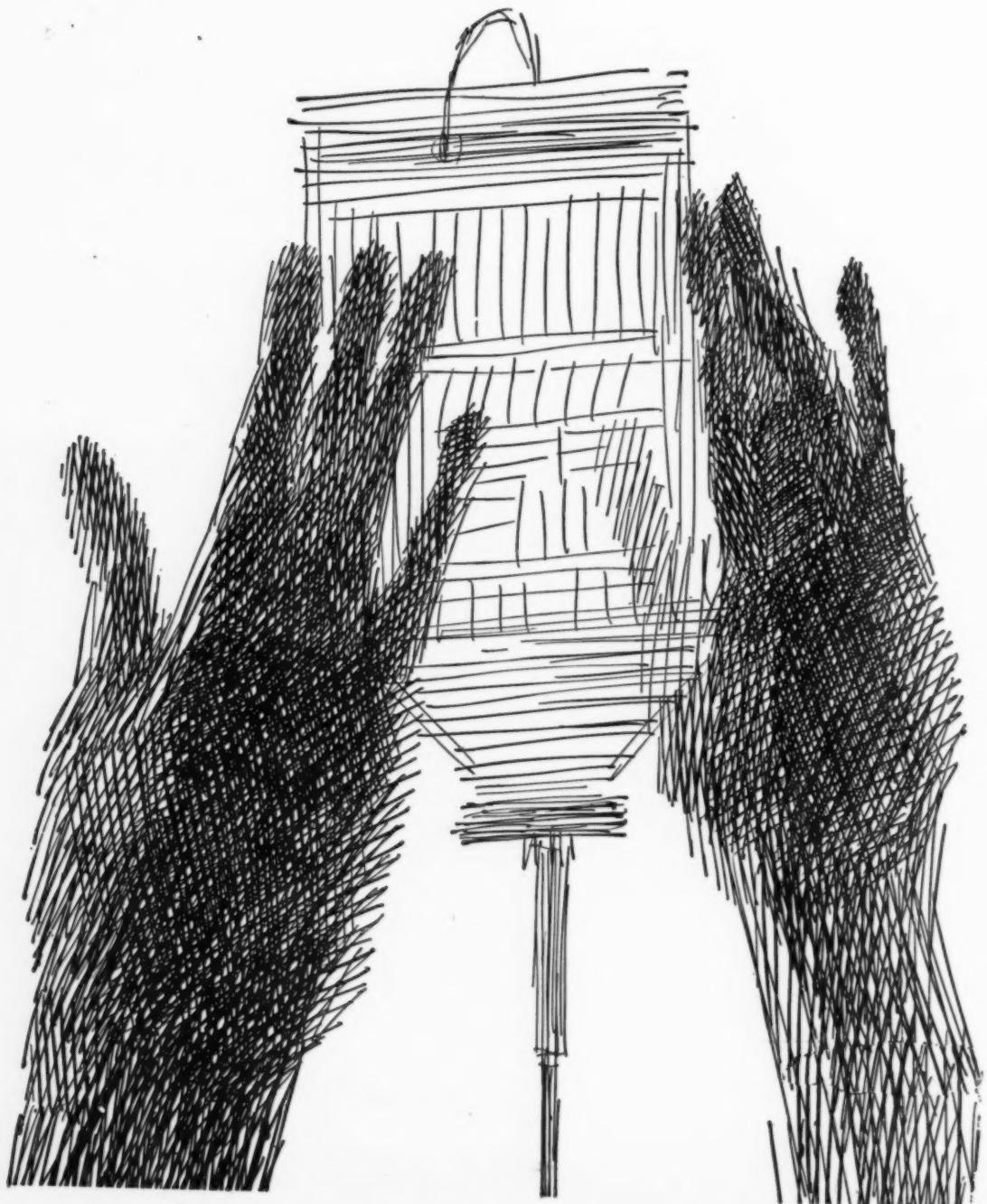
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(suite de la page 52)

Si l'accréditation est une chose souhaitable pour un hôpital, il faut que l'un des représentants de l'établissement traduise ce désir par des actes. Dans la majorité des cas, c'est l'administrateur qui met le projet à l'exécution, mais dans bien des hôpitaux, les membres du corps médical ou même ceux du conseil d'administration ont été à l'origine des démarches. La Commission tâche de faire autour de l'accréditation le plus de publicité possible, publicité principalement destinée à l'administrateur, au corps médical, et aux membres du conseil d'administration. Nous sommes encouragés par l'intérêt croissant dont bénéficie l'accréditation, en particulier de la part des conseils d'administration et des corps médicaux hospitaliers, et je ne crois pas pouvoir mieux décrire la situation qu'en citant le rapport fait par le Dr. Hollis à la Commission en janvier 1957:

"Je pense que c'est pour nous un encouragement de voir l'intérêt croissant accordé à notre programme, dans tout le pays, par les conseils d'administration et les corps médicaux des hôpitaux. Partout les docteurs désirent rencontrer le représentant et discuter avec lui de leurs problèmes et de leurs insuffisances. Ces docteurs montrent qu'ils apprécient la ligne d'action de la Commission en encourageant vos représentants à prendre le temps de les rencontrer. Cette ligne d'action paie, et notre programme, parfois considéré comme un tas de paperasse inutile et de demandes ennuieuses, parvient à être accepté comme étant une organisation valable et un bon principe. Lors de la réunion d'un corps médical, dans un secteur qui a fait de grands progrès ces deux dernières années, un orateur faisant partie de mes remarques disait; 'L'un des facteurs qui ont le plus contribué à créer parmi nous un esprit d'amicale collaboration a été l'application des conditions exigées pour l'accréditation définitive.'

La commission a toujours tenu à faire son possible pour aider les hôpitaux à résoudre leurs problèmes d'accréditation. Cependant, pour des raisons évidentes, il n'est pas possible d'employer un inspecteur à visiter des hôpitaux pour lesquels l'accréditation n'est qu'un vague et lointain projet. Il n'y a absolument pas assez d'argent ni d'inspecteurs pour financer un programme d'essais voués à l'échec. La Commission fera tout son pos-

sible pour répondre aux demandes écrites et le directeur recevra les représentants des hôpitaux sur rendez-vous à son bureau.

Lorsque la demande officielle a été reçue, et que l'inspecteur visite l'hôpital, il espère et désire pouvoir rencontrer les membres du conseil d'administration et du corps médical, et il se réjouira de l'occasion de discuter avec eux les problèmes de l'accréditation. Les inspecteurs des hôpitaux ont signalé qu'ils peuvent très vite se rendre compte du degré d'enthousiasme qu'éprouve un hôpital à l'égard l'accréditation d'après l'accueil qui leur y est fait. Quelques inspecteurs m'ont dit avoir visité des hôpitaux qui ne leur ont pas offert la moindre occasion de rencontrer des membres du corps médical ou du conseil d'administration. En ce cas, la réaction de l'inspecteur ne peut bien entendu guère faire de doute, étant donné que l'accréditation d'un hôpital réclame de la part de son personnel administratif et médical la preuve d'un effort de collaboration.

L'une des difficultés majeures dans nombre de nos hôpitaux d'aujourd'hui est l'encombrement des salles d'hospitalisation et de service. Dans bien des cas, l'inspecteur à du recommander un refus ou une acceptation provisoire par suite de cet encombrement. A mon avis, il faut bien admettre qu'il est impossible de dispenser des soins de qualité s'il y a des malades répartis dans les couloirs, les salariums, et cetera. Les administrateurs d'hôpitaux devraient se charger personnellement de parer l'évolution des besoins hospitaliers de leur communauté et mettre tout en oeuvre pour assurer la fourniture de services convenables.

Au cours d'une inspection, le premier souci de l'inspecteur est d'évaluer la qualité des soins dispensés par l'hôpital à ses malades. Il ne lui est pas possible de juger de la qualité des soins en allant dans les salles d'hospitalisation ou d'opérations se rendre compte du travail, et de la façon dont il est effectué. Son estimation de la qualité des soins doit nécessairement se baser sur l'examen des dossiers d'hospitalisation des malades. Nous autres hospitaliers savons tous combien il nous est difficile d'amener les médecins à tenir un dossier convenable en ce qui concerne la recherche du diagnostic et le traitement appliqué à un malade au cours de sa maladie. Les médecins, tout comme les autres, n'aiment pas manipuler des piles de "paperasses". Le médecin

est particulièrement vulnérable du fait qu'il a constamment affaire à une ronde en apparence interminable de questionnaires et de rapports dont chacun demande à être complété d'urgence. Dans un hôpital, ce n'est pas une tâche facile pour lui que de s'assoir et se mettre à remplir un long dossier en particulier quand il a vu le malade auparavant à son cabinet, et qu'il y conserve un dossier.

Si nous voulons de bons dossiers, je devrais peut-être dire des dossiers acceptables, il est très important que nous réfléchissions sérieusement à tous les moyens qui pourraient être utilisés pour y parvenir. Chaque hôpital devrait, en conséquence, étudier son propre problème et tâcher, par des méthodes pratiques, de faciliter au médecin la tâche de préparer et compléter son dossier de malade. Dans plusieurs hôpitaux les dossiers ont été améliorés par l'utilisation de méthodes plus simples que celle qui consiste à écrire à la main l'histoire des cas, les diagnostics, les notes d'évolution, et cetera. Une méthode qui offre de larges possibilités consiste à utiliser des machines à dicter, afin que le médecin n'ait pas à écrire le dossier. D'autres hôpitaux emploient, pour la salle d'opération et d'autres locaux, des sténographes médicales à la disposition des praticiens.

Un bon dossier n'a pas besoin d'être volumineux, mais il doit, bien entendu, fournir les données appropriées au cas. On peut contribuer fortement à l'amélioration de la qualité des dossiers médicaux en fournissant, pour l'histoire des cas, des formules imprimées adéquates qui incitent à enregistrer les renseignements essentiels avec le minimum d'écritures. Les formules d'histoire des cas sur lesquelles il suffit de cocher ou marquer d'une croix les mentions utiles ont ici une place limitée mais tout de même appréciable.

Une fois complété, le dossier médical est confié au service des Archives Médicales de l'hôpital. La tâche de vérifier si les dossiers sont complets, de les coder et les classer, et d'en extraire divers types de renseignements statistiques incombe au Service des Archives. Les renseignements à fournir aux comités d'examen des tissus médicale proviennent en majeure et pour les besoins de vérification partie de ce service. Il importe par conséquent que l'hôpital fasse tout son possible pour mettre sur pied

(suite à la page 80)

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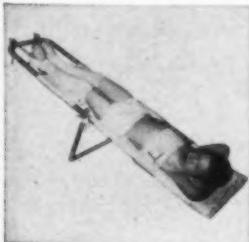
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L'accréditation
(suite de la page 78)

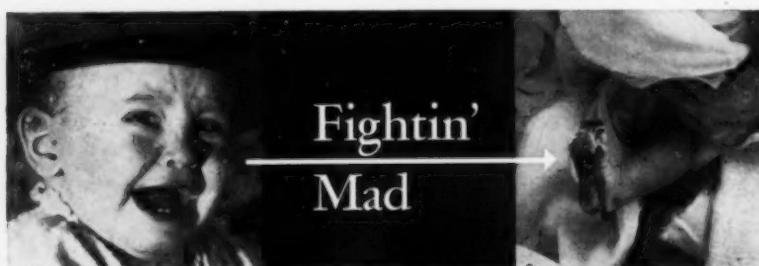
un service d'archives capable de fournir les renseignements requis pour l'accréditation. Le meilleur moyen d'y parvenir est de confier la charge de ce service à un(e) archiviste médical(e) formé(e) pour occuper ce poste et secondé(e) d'assistant(e)s également qualifié(e)s dans cette branche. Je sais très bien qu'il y a pénurie d'archivistes qualifié(e)s et qu'il n'en existe pas suffisamment pour satisfaire à la demande des hôpitaux. Néanmoins, tout hôpital devrait tâcher de

trouver une personne aussi qualifiée que possible pour diriger cet important service.

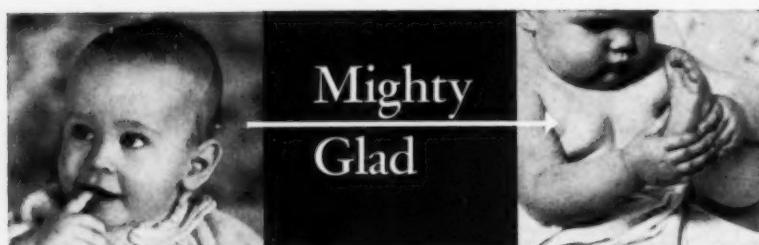
L'Association des Hôpitaux du Canada, grâce à son programme de formation d'archivistes médicaux aide à réduire cette pénurie. L'association cherche actuellement à élargir son programme et s'efforce d'amener un plus grand nombre d'hôpitaux à permettre que leurs facilités soient utilisées pour les besoins du programme de formation. C'est là certainement un domaine qui mérite l'appui financier du gouvernement. Les hôpitaux dé-

pourvus d'archivistes qualifié(e)s peuvent contribuer considérablement à l'amélioration de leur propre service en envoyant des personnes capables faire un stage de formation dans des hôpitaux qui possèdent des services d'archives fermement établis. Les grands hôpitaux peuvent rendre d'importantes services en l'occurrence.

Le progrès du programme d'accréditation dans cette province nécessite de la part de nos hôpitaux bien plus d'enthousiasme qu'ils n'en ont montré jusqu'à présent. Comme on l'a déjà souligné, il n'existe pas de voie facile menant à l'accréditation, du fait qu'il n'existe pas de limitation à la qualité des soins médicaux. Mais je crois qu'il vous faut bien admettre avec moi que la récompense en vaut la peine et que l'hôpital que se prévaut du sceau de l'accréditation peut à juste titre mériter le respect et la confiance de la communauté qu'il dessert.



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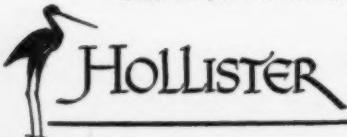
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Budgets

(continued from page 56)

and showing the rate of depreciation which will be allowed. No doubt the check list in the original *Canadian Hospital Accounting Manual* will be used as a guide.

Bad Debts

In 1958 hospital income will come from the usual sources, including patients, Blue Cross, et cetera. However, in 1959, when the plan goes into effect, hospital income, for a large part, will come

from the Commission. There will still be uninsured patients, non-resident patients, and patients of organized out-patient departments. Hospitals will be expected to maintain good collection procedure for patients not covered by the insurance plan and bad debts on this type of patient will only be allowed if it is evident that the hospital has taken full steps to collect these accounts.

Salaries and Wages

Several hospital administrators have pointed out that salaries

and wages for 1958 will not be decided until after the December 31 deadline for the filing of the 1958 budget with the Commission. This is a practical problem and in the explanatory notes to be sent along with the budget forms it is suggested that, if this applies to your hospital, you should complete your 1958 estimates showing the rates which you are now paying, modified by any salary schedule you may now have in effect.

In addition, we suggest that you put in the budget an estimated amount for your wage and salary increases. All submissions will be treated, of course, as confidential.

Indigents

Questions have also been asked on how indigents will be treated under the hospital insurance plan. This type of hospital patient comes within two groups. The first includes persons receiving categorical assistance such as old age security with medical welfare, old age assistance benefits, blind persons' allowance, and mothers' allowance. These persons will be insured under the plan and the premiums will be paid by the government to the Commission. Into the second group fall those persons who will be recognized by the municipality as medical indigents. The hospital will, therefore, be paid in full for the cost of both these groups.

It is recognized that there may be differences of opinion between hospital people and municipal officers regarding the second group of indigents. The Commission has arranged meetings with municipal welfare people to establish satisfactory definitions of what constitutes a medical indigent, as well as to set up a satisfactory method of solving differences of opinion as to who are medical indigents, between the two groups.

Payments to Hospitals

No payments will be made to hospitals under the insurance plan in 1958. They will be made to each hospital twice a month, starting in January, 1959. Each hospital will be paid the per diem standard ward cost which it incurs for insured patients. This will be calculated from the budget accepted by the Rate Board.

The total cost of operations of each hospital, as estimated for 1959, will be the starting point. There will be deducted from this

(continued on page 84)

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Budgets

(continued from page 82)

total cost the cost of the additional services given to private and semi-private patients over the cost of the services given to standard ward patients. This cost could be calculated by an involved formula based on a full cost study, but this would mean having various statistics from each hospital and much time spent in pro-rating expenses.

Therefore the federal and provincial governments have looked

for a simple formula, and it has been agreed that the cost of the differential between the standard and private and semi-private care will be estimated as a percentage of the difference in rates charged.

What the cost percentage will be is still under discussion with the federal government. Suppose we say that this cost is 60 per cent, as it is under the British Columbia hospital insurance plan. This means that the remainder of 40 per cent of the differential will not be offset against operat-

ing cost. It will be considered as a free fund which the hospital will retain for capital expenditures, to increase working capital, to reduce capital debt, or for any other purpose.

From total cost we have deducted the cost of extra private and semi-private services. The net cost resulting will then be divided by the estimated number of patient days, to arrive at the per diem cost to the hospital. This may be divided as between fixed and variable costs, and there may be other adjustments, but this substantially outlines the manner in which the per diem cost will be calculated, and on this basis hospital payments will be made.

Of course, total payments by the Commission will be for insured patients only. The hospitals will collect directly for uninsured patients, non-residents and those connected with the Department of Veterans' Affairs or the Workmen's Compensation Board. The Commission will require that these uninsured patients are charged at least the cost of standard ward care. This is a provision of the Hospital Insurance and Diagnostic Services Act.

Deficits

What happens if throughout the year the payments to the hospital are inadequate to cover actual operating costs due to unforeseen expenses, unusually high occupancy, or errors in preparing the budget prior to the commencement of the year? This sort of difficulty will be discovered in working with the 1958 budget, and some of these points will not, therefore, recur in 1959. However, there is no doubt that actual costs of some hospitals will be higher than their budgets and in spite of good administrative control they may operate at a deficit.

There are two methods by which this will be handled:

1. Throughout the year the monthly statement sent to the Commission showing the highlights of month-to-month operations will provide an opportunity to see how closely actual operations match with the budget. If a deficit shows it will be possible to visit the hospital for discussion; and the Rate Board may amend its payments.

2. At the end of December when the annual financial statement is finalized for the year, it will be matched with the budget. This will be of interest not only to your

(concluded on page 86)

A black and white photograph showing a nurse in a white uniform and cap pushing a patient in a wheelchair. The patient is wearing a light-colored hospital gown. A large, black hydraulic lift arm is attached to the side of the wheelchair, extending upwards to support the patient's weight. The lift is mounted on a four-wheeled base. The background is a plain, light-colored wall.

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Budgets

(concluded from page 84)

board and administrative staff, but also to the Commission.

If, after year-end adjustments, there is a deficit before charging depreciation on buildings and interest on capital debt, the Rate Board will study the statement to see how the deficit arose. At this time no policy has been set up as to how the deficit will be handled. Much depends on what caused the deficit.

Many hospitals may, by careful management and sound planning

and budget control, be able to operate at a surplus. When the Commission is setting its policy on deficits, it will also set its policy on surpluses.

Conclusion

There is a tremendous challenge to hospital people to control their costs in the next two years. The controlling of rising costs due to inflation, and at the same time meeting the needs of the public for more hospital care, will continue to demand the highest calibre of planning and control by boards and administrators.

All of us want the hospital insurance plan in Ontario to achieve a name not only for capable and adequate hospital care, but also for efficiency and economy.

Hospital people in the past have been known for their conscientious service to the public in spite of many difficulties. In the future there will be a stronger challenge than ever to continue to operate wisely and to plan carefully. Budgets are one of the best tools for sound planning and control.

Tranquillizers

Tranquillizers may be useful in treating anxiety and tension which are severe enough to make the individual ineffective. But their phenomenal demand arises chiefly from a desire of millions to suppress the stresses and strains of everyday life, to blunt themselves against the pin-pricks of environment, to make them indifferent to their problems. A proud claim made for one drug was that on normal subjects it so relieved their "hostilities" that they couldn't even start an argument.

In areas of the world where living consists in toiling at a subsistence level, with no hope of a better future, whole populations blunt their misery with cocoa leaves or hashish. Are we in a position to pity them, while apparently trying to sedate and relax ourselves into a generation of ciphers?

Anxiety and tension are inherent in the solution of problems, and the solving of problems is a continuing process in the development of an individual or a society towards maturity. Escape into indifference is decadence. Our civilization has been built on the divine discontent of tense men. Had they not in every generation become anxious over problems, we might still be ploughing with pointed sticks. Perhaps Columbus could have discovered the New World while taking tranquillizers, and Beethoven might have been able to compose his symphonies, but I submit that if they had been full of meprobamate they wouldn't have bothered.—T. F. Rose, M.D., in the Canadian Medical Association Journal.

When we raise our standards of physical fitness higher than mere freedom from contagious disease, we find that we are in the realm of personal effort. The responsibility for achieving positive good health is upon us individually.—Monthly Letter, Royal Bank of Canada.

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(suite de la page 36)

demande additionnelle causée par le coût de construction des hôpitaux pendant la période allant du 1er janvier 1958 au 31 mars, 1958.

"On espère que cet élargissement de l'aide fédérale aux provinces, en ce qui concerne les capitaux nécessaires à la construction d'aménagements hospitaliers conformes aux conditions d'attribution de la subvention à la construction hospitalière, aura un effet salutaire non seulement sur l'encouragement à la construction d'aménagements hospitaliers nécessaires, selon des plans bien étudiés, mais encore sur les débuts de la mise en application des accords conclus avec les provinces relativement à la Loi sur l'Assurance Hospitalisation et les Services de Diagnostic. De plus, le gouvernement pense que l'attribution de ces crédits additionnels maintenant s'avérera opportune en stimulant de nouvelles constructions dont on peut espérer qu'elle réduiront le chômage, le cas échéant, dans les localités où ce genre de construction serait entrepris."

Les instances de la part de l'Association des Hôpitaux du Canada, mentionnées par le Ministre, prirent la forme d'une requête que les dirigeants de cette association lui présentèrent en Septembre 1957. (Voir le "Canadian Hospital" de novembre 1957, page 35). Cette requête demandait que soient considérés les points suivants:

Que les subventions à la construction hospitalière soient prorogées pour une autre période de cinq ans à compter du 1er avril 1958.

Que le champ d'application des subventions soit étendu de sorte qu'un projet de construction comprenant n'importe quel genre de service d'hôpital ou de logement d'employés d'hôpital puisse parvenir à ouvrir droit à la subvention.

Que la formule sur laquelle les subventions sont calculées soit modifiée, et que les montants alloués soient augmentés de façon que la contribution du gouvernement du Canada à chaque projet de construction d'hôpital atteigne environ le tiers du coût total.

La requête était basée sur des résolutions adoptées par l'assemblée biennale de l'Association des Hôpitaux du Canada en mai, 1957, ainsi que sur des résolutions prises par les associations membres et les conférences catholiques lors de leurs congrès annuels. Bien que l'augmentation de l'attribution unitaire de base soit inférieure à celle demandée dans notre requête, il faut noter que le nouveau tarif rétablit la valeur relative des subventions à son niveau de 1948, en tenant compte de l'augmentation subie depuis lors par les coûts de construction. Il faut également noter que le gouvernement continuera à accorder les subventions au moins aux conditions annoncées, pendant les cinq prochaines années fiscales. Cela peut signifier que la porte reste largement ouverte à l'éventualité d'une révision au cours de cette période.

Etant donné que la nouvelle subvention pour rénovations et modifications majeures n'a fait l'objet que d'une brève mention, il faudra attendre le décret ministériel relatif à cette subvention pour connaître avec certitude l'étendue de son champ d'application.

Les nouvelles bases d'attribution des subventions fédérales à la construction devraient aider en particulier ces hôpitaux où des constructions ont été projetées, mais remises à plus tard par suite de l'insuffisance des fonds. Sans aucun doute, dans bien des cas, ces subventions vont signifier un démarrage imminent de projets dont la réalisation s'impose aujourd'hui.



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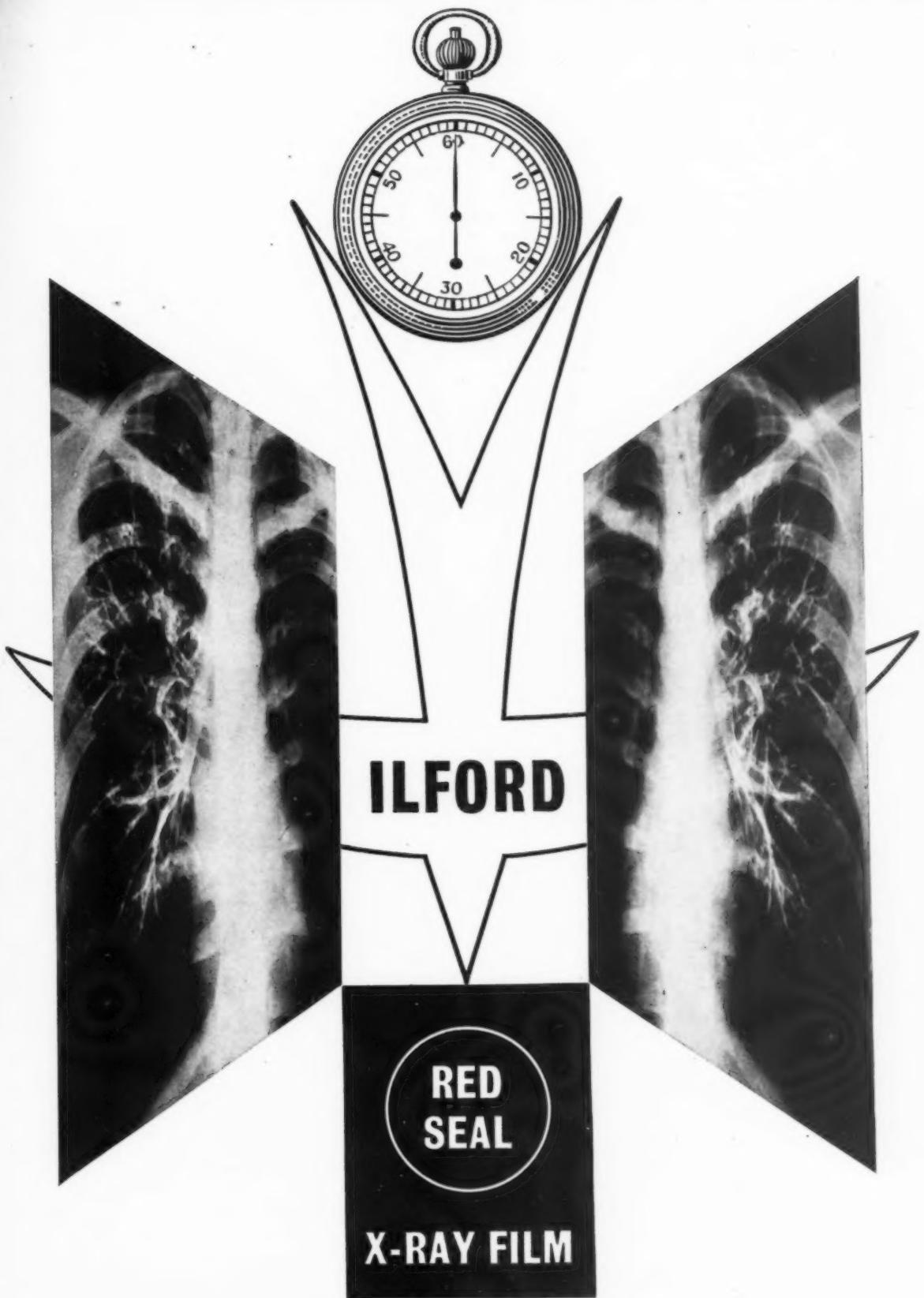
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Provincial Notes
(concluded from page 58)

Sketch plans of additions to Scarborough General Hospital, drawn up by architects Govan, Ferguson, Lindsay, Kaminker, Langley, and Keeleystide, call for extensions to the north and east of the present building which will double existing facilities.

At St. Andrew's Hospital, Midland, patients not covered by insurance plans will have to pay a \$40 deposit on admittance to be applied against future bills. Bills

will be issued weekly and the hospital will pay as it goes in an attempt to bolster its sagging finances.

Quebec

A new call system has been inaugurated at the Queen Elizabeth Hospital of Montreal. Signals from the switchboard are picked up by five-ounce receiving sets carried by the doctors. When a doctor hears his "beep" he calls the switchboard to take the message.

Construction on a hospital for Sept-Iles is to begin in the spring. The proposed hospital would have 75 beds.

Barrie Memorial Hospital, Ormston has received \$10,000 of its \$40,000 provincial grant, and will receive similar amounts for the next three years. Added to public donations the grant will help to pay the hospital's capital debt and to complete the nurses' residence.

The new Hôpital St. François de la Sarre has been officially opened.

Sketch plans are being prepared for additions to Ste-Anne Hospital, Baie St-Paul. The extension is to provide a chapel, classrooms, a laundry and 600 additional beds in four new wings. The architect is Maurice Mainguy, Quebec.

The Jewish Hospital of Hope was presented with an anaesthetic machine by St. George's No. 10 Masonic Lodge of Montreal.

Construction of a hospital for the aged and chronically ill at St. Tite will begin in the spring. The provincial government is providing an initial grant of \$1,000,000. To be built in an X shape, the new hospital will contain 250 beds.

A new wing has been added to the Notre-Dame-du-Rosaire Hospital, Bedford. As well as 24 patient beds, the wing contains a surgery room with oxygen, a room for the doctors, two rooms for pharmacy, and two large sun rooms.

New Brunswick

The first cobalt bomb to be used in the Maritimes has been installed in the new radiotherapy department of the Saint John General Hospital. Cost of the equipment is approximately \$54,000.

The new nurses' residence at Moncton Hospital has been officially opened.

Nova Scotia

Highland View Hospital, Amherst, is receiving a combined federal-provincial grant totalling \$16,000 for x-ray equipment. The hospital will be responsible for providing larger accommodation and renovated rooms.

A first aid emergency kit to be used in the ambulance was presented to Sutherland Memorial Hospital by the Pictou Kinettes Club. The Kinsmen Club has provided the hospital with aluminum storm and screen windows.

Roseway Hospital, Shelburne, has been fully accredited by the Joint Commission for three years.

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Gaseous Sterilization

A team of scientists of the physical defense division, U.S. Army Chemical Corps, has discovered a new bactericidal gas. This is beta-propiolactone—a compound which had been used previously for sterilization only in aqueous solution. As a gas it acts as effectively as formaldehyde vapour, but is more rapid and has fewer adverse side effects.

The gas, it has been stated, will be proven, after more studies, to have important applications with possible use in sterilizing operating rooms and nurseries within hospitals, et cetera. The information collected about this gas was disclosed by C. R. Phillips, Ph.D., chief of the U.S. Army Chemical Corps, in one lecture of a series on sterilization techniques sponsored by Becton, Dickinson Ltd.

In his paper, he reviewed early work with formaldehyde and the more recent development of ethylene oxide mixtures. On formaldehyde gas Dr. Phillips stated that it did have many practical applications, particularly in treating large and relatively uncluttered, enclosed spaces, but it was unsatisfactory for materials and objects such as woollen uniforms and potentiometers which should be sterilized in the absolute sense of the term.

In reference to ethylene oxide, Dr. Phillips summarized its characteristics by reporting that it damages few materials; that it is "truly bactericidal and not bacteriostatic in effect", and "that the list of organisms reported killed by ethylene oxide is impressive". He also stated that since it "is a true gas which does not polymerize or absorb on most materials, . . .

simple airing quickly removes all residual chemicals from most objects."

He listed penicillin and other biologicals, hospital bedding, ophthalmic, urological and other types of medical instruments, eggs (through the shells), whole barrels of spice and even artery sections used for surgical transplants, as examples of the great variety of articles reported sterilized by ethylene oxide.

As disadvantages of ethylene oxide he noted its slowness of action (at room temperatures and in the usual concentrations reached within a cabinet, six hours or more are often required); that in rubber and certain plastics it actually dissolves and then evaporates slowly; and that it can damage some plastics if, due to engineering difficulties, the gas converts to its liquid state.

"The very fact that with this gas we can sterilize many objects or materials hitherto unsterilizable", Dr. Phillips said, "places the disadvantages of ethylene oxide into the category of unavoidable nuisances which we have to tolerate in order to do certain jobs we can accomplish by no other means known today."

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Saskatchewan Spring Institutes

The Saskatchewan Hospital Association has planned a series of one-day Spring Institutes, particularly designed for hospitals under 50 beds. The institutes will be held as follows: Swift Current on April 9; Weyburn on April 11; Yorkton on April 16; Melville on April 23; North Battleford on April 26.

The association urges that each hospital see that several of their trustees are represented at the meetings.

Hospital Feeding Session

Hospital personnel in general and dietitians in particular will be interested in the session on "hospital feeding" at the Canadian Restaurant Association's annual convention. The feature address on this subject by Margaret Ketchen of Toronto General Hospital, to be delivered at ten o'clock on the morning of March 26, will be followed by a panel discussion. "Canada's largest food service show" will be held in Exhibition Park, Toronto, Ontario, from March 24 to 27.

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Ontario Government Increases Construction Grants

Capital construction grants are to be doubled in most categories by the Ontario provincial government. With the announcement of federal grant increases, Ontario is providing greatly stepped-up assistance which came into effect on the same date, January 1, 1958. In many instances the grants continue to exceed those made by the federal government.

Active treatment beds will now receive \$2,000, rather than \$1,000; chronic and convalescent rates have been raised to \$3,000 from \$2,000; and bassinets will get \$666.66 as compared to the former rate of \$333.33. Grants for nurses' beds are increased from \$1,000 to \$2,000, and tuberculosis beds have been stepped-up from \$2,500 to \$3,000. A new grant for interns' beds is set at \$2,000.

Space for emergency and outpatient services, and for diagnosis and treatment, formerly \$1,000, is now \$2,000 for every 300 square feet.

Nothing's more responsible for the good old days than a bad memory.—*English Digest*.

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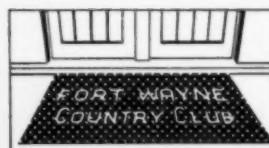
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Auxiliaries
(concluded from page 62)

patients. The auxiliary's special project for 1958 is modernization of the hospital's infant formula rooms.

Progress Reports

Since the 520 members of the Women's Auxiliary of the Oakville-Trafalgar Memorial Hospital, Oakville, Ontario, are spread over such a large area, instead of holding regular meetings the auxiliary sends out brochures on work pro-

cess. In eight years the hospital served by the auxiliary has grown from a made-over house to a 170-bed institution. The final progress report for the past year showed that the auxiliary was able to raise \$9,062. The February project was suited to the scattered membership — a Play-at-Home Bingo.

A Good Beginning

At their first meeting of this year the Ladies' Advisory Board of the Charlotte County Hospital, St. Stephen, N.B., voted to spend \$800

to purchase linens for the hospital. It was reported that a utility table had been purchased for the student nurses' quarters, and that enough jars of jams and jellies had been donated to last the hospital until June.

Help Where It's Needed

The Women's Auxiliary of Lachine General Hospital, Montreal, Quebec, has been purchasing equipment. A fluorescent light fixture and foam cushions for the benches have improved the appearance and comfort of the front hall. An ironing device, a nurses' uniform sleeve costing \$175, will eliminate the expense of sending uniforms out of the hospital for pressing. Three canvas tubs for conveying linen, badly needed by the laundry department, were purchased at a cost of \$352.

Birthday Club Present

The first project of the Birthday Club of the Women's Auxiliary of the Reddy Memorial Hospital, Montreal, Que., was the presentation of an incubator to the hospital nursery. The auxiliary last year raised \$7,800 for the hospital.

South Seas in Sherbrooke

It was Quebec in February, but inside the William Street Armoury at the Linen Ball it was the tropical South Seas. The decorating committee of the Ladies' Auxiliary of Sherbrooke Hospital worked overtime to produce the tropical atmosphere for the annual ball.

Life-size natives, made by an auxiliary member, peered out at the guests from imitation palm trees around the ballroom. A south-sea mural painted by Peter Lock, Master at Bishop's College School, formed a background. The ceiling was hidden by netting that was bright with giant, tropical flowers made by a girls' art class. The tables also contributed to the decor. For guests who wished to enter into the spirit of the theme there was even a native girl selling leis.

Top Brass

A harried business executive went to his physician to get a prescription for sleeping pills, only to find that he was allergic to sedatives.

"What about some of this twilight sleep I've read about?" he asked the doctor.

"Oh, that's only for labour," was the reply.

"Good heavens!" exclaimed the executive, "haven't you anything for management?" --H. M.

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Emotions and Diet
(concluded from page 74)

patient enters a hospital. Therefore it is important that everyone who has contact with that patient shows an understanding, is tolerant and sympathetic, but firm. This should be true not only of the doctor, but of the nurse, dietitians and all in attendance as well.

One of the most potent aids we have for improving a person's outlook or feeling is an attractive, appetizing menu. Sick people, whether sick in body or mind, can't bear the sight of an overful plate

—especially if it is served in an unattractive manner. The content is limited and the quality may be too, but the amount and flavour and the way it is served can be enhanced.

In interviewing patients to discuss diets, it is important for the dietitian to keep in mind the fact that she is dealing with sick, often anxious, persons. They may, as I mentioned, be unreasonable and lack understanding and tolerance, but it is necessary to take time to explain in detail the reasons for certain dietary measures. The new

diabetic is going to have little knowledge of diet and he must learn, without fear and threats, what might happen if he strays from his diet. At the same time he should learn that he can be a well person if he keeps to his diet, takes his insulin and looks after himself.

I will always remember a patient I saw treated for a peptic ulcer. He was an anxious person and the doctor had reassured him strongly —by telling him to stay on his diet, and that he would be well if he didn't have a hemorrhage or a perforation. It was the last few words that the anxious person remembered, and when I saw him he was just waiting for one of these catastrophes to happen. One must offer strong reassurance and understanding without alarming or confusing the patient.

On the whole it is important for the dietitian to remember that she is dealing with a human personality with very individual reactions to food and treatment. It is not enough to fill a diet prescription from a diet manual without considering the feelings of the person who will be eating the diet as planned. It is the whole man who must be treated.

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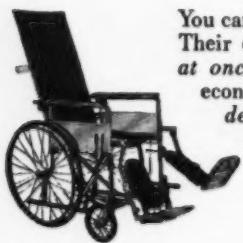
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Sterling Surgical Supply Co., 240 3rd Ave. S.

C.H.A. Library Acquisitions

THE following is a representative list of publications which have been received in the library of the Canadian Hospital Association during the past year. In addition to the collection of books, pamphlets, and manuals, the library maintains files of articles clipped from journals on subjects pertaining to many aspects of the hospital field. Package libraries are available on request for a three-week loan period. There is no charge for this service.

General Administration

Hospital Organization and Management: Malcolm T. MacEachern, M.D. (3rd edition). Physicians Record Co., Chicago, Ill., 1957. Pp. 1052.

Administrative Manual: Tennessee Hospital Association, Nashville, Tennessee. Outline of Administrative Manual for Voluntary Hospitals of Medium Size, 1955-1956. Pp. 94.

Hospitals Visualized: Ray E. Brown and Richard L. Johnson. American College of Hospital Administrators. Manual revised 1957. Pp. 134.

Model Constitution and By-laws for Voluntary Hospital: American Hospital Association. Manual revised November 1956.

Departmental

The Institutional Laundry As I See It: Sister Mary Celeste, S.S.M., R.N. St. Mary's Hospital, St. Louis, Mo., 1957. Pp. 252.

Cost Finding for Hospitals: American Hospital Association. Manual, 1957. Pp. 136.

Hospital Services Manual—Pharmacy; Plans, Equipment, Supplies, Organization, Minimum Standards: U. S. Department of Health, Education and Welfare, Public Health Services. Revised 1957. Pp. 40.

Physical Therapy Manual—Essentials of a hospital department: American Hospital Association, 1957. Pp. 42.

Nursing and Patient Care

Psychology of Human Behavior for Nurses: Lorraine Bradt Dennis. W. B. Saunders Company, Philadelphia, Pa., 1957. Pp. 250.

Encyclopedic Guide to Nursing: Helen F. Hansen. McGraw-Hill Company of Canada, Limited, Toronto, Ont., 1957. Pp. 405.

Law Every Nurse Should Know: Helen Creighton. W. B. Saunders Company, Philadelphia, Pa., and London, Eng., 1957. Distributed in Canada by McAinsh and Co., Toronto, Ont. Pp. 197.

Practical Nursing Today — Attitudes, Knowledge, Skills: Esau, Fallon, Frentzos, Phillips and Tourtillott. G. P. Putnam's Sons, New York, N.Y., 1957. Pp. 527. Moral Handbook of Nursing: Hayes, Hayes and Kelly. The MacMillan Co., New York, N.Y., 1956. Pp. 180.

A Guide for Psychiatric Aides: Charlotte R. Rodeman. The MacMillan Company, New York, N.Y., 1956. Pp. 234.

The Winnipeg General Hospital School of Nursing, 1887-1953: Ethel Johns. Published by the Jubilee Committee of the Alumnae Association, 1957. Pp. 87.

The Nurse and the Outpatient Department: Audrey Windemuth, R.N. Published by The MacMillan Company, New York, N.Y., 1957. Pp. 580.

The Patient and the Mental Hospital: Greenblatt, Levinson and Williams. Published by The Free Press, Glencoe, Illinois, 1957. Pp. 658.

Manual of Recovery Room Care: John M. Beal, M.D. Published by The MacMillan Company, New York, N.Y., 1956. Pp. 111. How to study the nursing service of an out-patient Department—A manual to help hospitals evaluate nursing activities: U. S. Department of Health, Education and Welfare, Public Health Service, 1957. Pp. 75.

How to study supervisor activities in a hospital nursing service—A manual for studying the supervisor in her work situation: U. S. Department of Health, Education and Welfare, Public Health Service, 1957. Pp. 47.

Related Literature

Guide to Medical Terminology: Wallace and Anne Clark. Published by F. A. Davis Company, Philadelphia, Pa., 1956. Pp. 130.

Organized Home Medical Care in New York City: Hospital Council of Greater New York. Harvard University Press, Cambridge, Mass. Published in Canada by S. J. Reginald Saunders and Company Limited, Toronto, Ont., 1956. Pp. 538.

The Cost of National Health Service in England and Wales: Abel-Smith and Titmuss. Cambridge University Press, England, 1956. Pp. 176.

(concluded on page 102)

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Selected Papers of Haven Emerson:
The W. K. Kellogg Foundation, 1957. Pp. 507.

Nutrition and Diet Therapy In Relation to Nursing: Marie V. Krause. Published by W. B. Saunders Company, Philadelphia and London, 1957. Distributed in Canada by McAinsh and Company Limited, Toronto. Pp. 621.

Prevention of Chronic Illness: The Commission on Chronic Illness. Published for the Commonwealth Fund by the Harvard University Press, Cambridge, Mass. Published in Canada by S. J. Reginald Saunders and Company Limited, Toronto, 1957. Pp. 338.

Remotivating the Mental Patient: Mering and King. Published by the Russell Sage Foundation, New York, 1957. Pp. 216.

Getting Ready for Parenthood: Mario A. Castallo, M.D. Published by the MacMillan Company, New York, 1957. Pp. 192.

You and Your Operation: Benjamin R. Reiter, M.D. Published by Brett-MacMillan, Limited, Toronto, Ont., and the MacMillan Company, New York, 1957. Pp. 150.

Women Doctors of the World: Esther Pohl Lovejoy, M.D. Published by The MacMillan Company, New York, N.Y., 1957. Pp. 413.

The Rehabilitation Centre: G. Gingras, M.D. Manual (2nd edition), 1956. Pp. 31.

Other Hospital Literature

Morbidity in the Municipal Hospitals of the City of New York: Fraenkel and Erhardt. Published by Russell Sage Foundation, New York, N.Y., 1955. Pp. 229.

Medical Negligence . . . being the law of negligence in relation to the medical profession and hospitals: The Right Hon. Lord Nathan. Published by Butterworth & Company Ltd., London, Eng., 1957. Pp. 218.

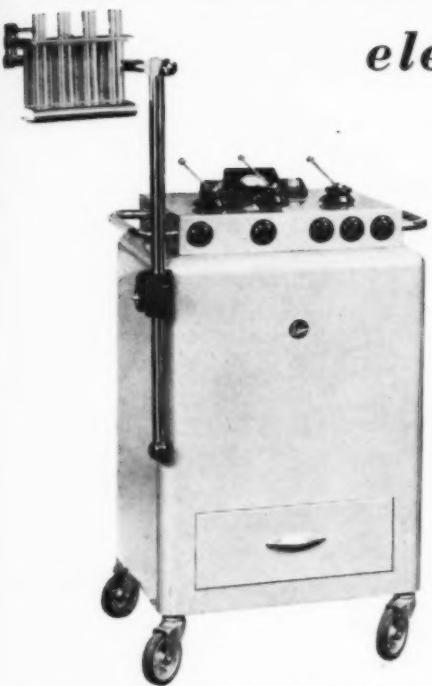
Emergency Removal of Patients and First-aid Fire Fighting in Hospitals: Manual. American Hospital Association and National Safety Council, 1956. Pp. 59.

Hospitals and the Law — selected court decisions that affect hospitals. Reprints from Hospital Management Journal. Pp. 49.

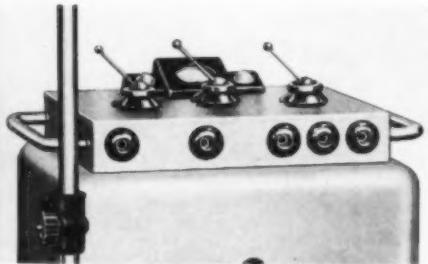
Building and Equipment Sanitation Maintenance — Principles and Practice: Barron and Burner. Manual published by Association of American Soap and Glycerine Producers, Inc., New York, N.Y., 1957.

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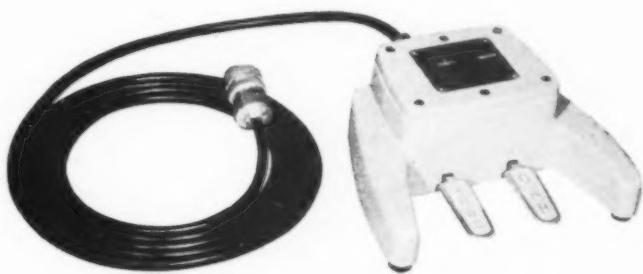
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High levels of power in both circuits is assured even if line voltage entering the operating room is inadequate. The line voltage control can be used to adjust and compensate for either high or low power levels, bringing the operating voltage to the proper level. This assures peak performance at all times.

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Graduate of Extension Course in Hospital Organization and Management, Member of American College of Hospital Administrators, with 20 years experience in hospital administration, seeks position. Toronto or vicinity preferred. Please write to Box 315M, The Canadian Hospital, 57 Bloor Street West, Toronto 5, Ontario.

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Laboratory Technician required immediately. Apply giving full details as to experience and salary expected, to Business Manager, Ongwanada Sanatorium, Kingston, Ontario.

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Occupational Therapist required immediately. Apply, giving full details as to experience and salary expected to—Business Manager, Ongwanada Sanatorium, Kingston, Ontario.

Accountant Wanted

For general hospital of 286 beds in Toronto area. Capable of keeping general ledger, taking off financial statements and returns. To assist in office supervision. Please send full details and references to Box 326W, The Canadian Hospital, 57 Bloor Street West, Toronto.

Position Vacant

Assistant Director of Nursing Service. Position requires qualifications of BSc in Nursing with experience in Administration. Applications to be made to Director of Nursing, Royal Alexandra Hospital, Edmonton, Alberta.

Physician Wanted

For Mount Sinai Sanatorium. Also expected to take part in research investigations. Provincial License not necessary, but helpful. Apply in writing to Dr. M. Aronovitch, Medical Director, 4119 Sherbrooke St. West, Montreal, Quebec.

Laboratory Technologist Wanted

For 100 bed hospital, good personnel policies, modern facilities. State salary expected. Apply to Superintendent, Lady Minto Hospital, Cochrane, Ontario.

Superintendent Wanted

For 70 bed general hospital directly responsible to administrator of Tri Hospital system. Salary commensurate with experience and ability. Write Leon Bennet-Alder, North Country Hospitals Inc. Gouverneur, N.Y.

X-Ray Technician Wanted

Female, registered preferred, in 100 bed accredited hospital. For further details apply to Administrator, Norfolk General Hospital, Simcoe, Ontario.

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Mary A. Johnson Associates welcomes inquiries from Hospital Trustee and Administrative and Department Head Level Personnel for Hospital and Medical Group positions.

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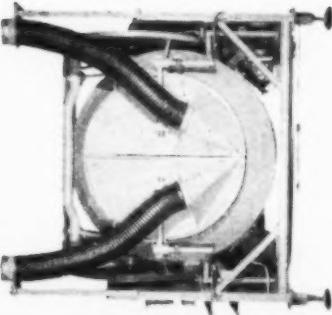
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Required for modern 300 bed, well equipped general hospital. This progressive industrial city of 45,000 is growing; it is a summer resort area located on the shores of Lake Huron and St. Clair River.

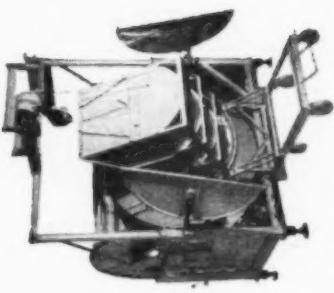
This fully approved hospital (JCAH) has approved schools for nurses, laboratory technologists, X-ray technicians, and is approved for intern training.

Qualifications for applicants include registration in Ontario, at least a bachelor's degree in Administration, and successful experience in the field of Nursing Education as well as in Nursing Administration. For more details and literature concerning the position and Sarnia, write to Personnel Director, Sarnia General Hospital, Sarnia, Ontario.

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*PURKETT PRE-DRYING CONDITIONING TUMBLER

In the 48" size there are the PCT*, the Heat Conditioner and the Unheated models Highly efficient for smaller operations.

Twenty Years Ago

From the Canadian Hospital,
March, 1938

At the meeting of the Association of the Registered Nurses of the Province of Quebec, it was stated that all but two of the training schools for nurses in the province are now on the approved list. It was pointed out that there are approximately one-third of the students who do not meet the requirements of the proposed curriculum, and the hope was expressed that those without the suggested educational requirements of junior

matrikulazione would not be accepted by any school of nursing in the near future.

The Hamilton General Hospital, Hamilton, Ontario, has installed a special tank for the exercise of paralyzed limbs; this is in conformity with the treatment of poliomyelitis cases as developed at Warm Springs, Ga., and the Hospital for Sick Children, Toronto.

CHETICAMP, N.S.—A new hospital containing about 50 rooms in all, is nearing completion at Cheticamp in Inverness County. This hospital is located on the com-

paratively new Cabot Trail, which now encircles Cape Breton Island, and is located at probably the most striking stretch of shore line in the Maritimes. As the grandeur of the scenery in this area becomes better known, the tourist traffic will increase, without doubt, and the hospital should prove of real value to tourists as well as to the large fishing and agricultural community resident in that section of the island.

LONDON, ENG.—English schoolboys are apparently receiving a remarkable education. *The Hospital*, London, quotes from an article in Guy's *Hospital Gazette*, "It was eventually realized that the patient suffered from a Claude-Bernard-Horner syndrome. This, as every schoolboy knows, is a unilateral paralysis of the cervical sympathetic nerve, resulting in tropic disturbance on one side of the face. . . ."

Our surplus medical men might make a living over there as tutors—or perhaps not!

Everything comes to him who hustles while he waits.—Thomas Edison, from *Wisdom*.

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... Across the Desk

News Released by Hospital Supply Houses

By C.A.E.

New Tinted Aeroplast

Aeroplast plastic protective surgical dressing is now available in two additional sizes, with a yellow tint added for visual indication of the area being dressed and the amount applied. The three ounce size is suggested for the physician's office, surgical dressing carts and for patient use. Large twelve ounce size is economical for use in the operating room. The original, clear Aeroplast is still available in the six ounce container.

Aeroplast is a transparent film dressing which excludes bacteria, is non-macerating, non-sensitizing, and does not adhere to raw wound surfaces, thus encouraging a clean, primarily healed wound. Aeroplast adapts to any body contour, permitting satisfactory dressing of awkwardly situated wounds without uncomfortable bulk. This method of dressing allows the physician to evaluate healing progress at will without removing the dressing. Aeroplast is sterile. For complete details contact Fisher & Burpe Limited, Montreal, Toronto, Winnipeg, Edmonton or Vancouver.

Stafford Foods Creates New Posts as Product Lines Expand

J. H. Stafford, President of Stafford Foods Limited, announces that Paul E. Drouin has been appointed bulk sales manager for Ontario. Mr. Drouin's 25 years' service in the bulk field will mean that he brings valuable experience to his new post.

This appointment is in step with

the company's aggressive policy of broadening activities in the grocery industry by undertaking the processing and merchandising of a number of new lines. Foremost is the production of ketchup, which the company views as a volume line. It will be packed in No. 10 tins and marketed in cases of six tins each.



The company has also added olives to its condiments section. These will be the Manzanilla variety, which will be stuffed, and the Queens, medium variety. Both varieties will be packed in one gallon jars.

The company is re-entering the spice business. It was active in this trade from 1935 to 1942 and since then has never ceased grinding and blending spices for its own use. It will pack and market four varieties in 10 oz. sifter top jars and 15 varieties in two-pound tubes. In the same section the company will process and market minced onions in three and 20-pound tins and sliced onions in 1½ and 30-pound tins.

Wilmot Castle Appointment

Bruce Babcock has been named manager of surgical operating

table sales at Wilmot Castle Company, Rochester, New York.

The position grows out of the addition of a new surgical operating table to the company's line of hospital, industrial, and medical-dental lighting and sterilizing equipment.



Bruce Babcock

Mr. Babcock joined Wilmot Castle in 1950, serving for two years as a Hospital Division sales representative in the New York City area. In 1952 he moved to Rochester to organize and head the company's television department, a position which he continues to hold. He has also served as hospital division office manager.

Schering Supports Research

Two Queen's University medical research experts have found a new financial ally in their study of anti-coagulant agents in the treatment of coronary heart disease. Dr. W. K. MacDonald, research director of Schering Corporation Ltd., Montreal ethical drug manufacturers, placed a Schering Corporation cheque for \$6,750 in the hands of Ford Connell, M.D., professor of medicine at the university, and his research associate, George A. Mayer, M.D.

Dr. MacDonald said Schering is keenly interested in progress in treatment of atherosclerosis, an arterial disease which causes strokes and coronary thrombosis. The company regularly gives grants to support research in various fields of medicine, and in 1957 endowed a research fellowship for Canadian medical schools. The grant to the anti-coagulant research project at Queen's, is a new departure for Schering.

(continued on page 110)

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Quick and easy pouch changing made possible by A.B.C.'s exclusive feature.

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The plastic rings and pouches covering the stoma are completely odor resistant.

4—Economical Dependable

Made of strong durable plastic assuring long life.

5—Lightweight Comfortable

Weights only 3 oz. Sufficient ring depth to protect clothing from stoma.

5

REASONS WHY THE A.B.C. COLOSTOMY KIT IS PREFERRED BY THOUSANDS

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37 Front Street, E., Toronto, Ont.
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Across the Desk
(concluded from page 108)

Dr. Connel and Dr. Mayer have been working on the anti-coagulant investigation for five years and have developed unique control methods. The current phase of the research is an expansion into investigation of the effects of anti-coagulants other than their anti-clotting action.

Appointments at Lily Cups Limited



T. Neil Armstrong



Gord Loree

H. R. Kobrick, executive vice-president of Lily Cups Limited, has announced the formation of an Ontario sales division structure. T. Neil Armstrong, former district sales manager has been promoted to Ontario division manager and Gord Loree, former sales representative becomes central Ontario district manager. This move will improve present service and will facilitate Lily Cup's current expansion program into other lines of cups and containers.

Ohio To Distribute Cardiological Equipment

On February 1, 1958 Ohio Chemical acquired the franchise to distribute in the United States and Canada electronic cardiological equipment manufactured by Dallons Laboratories, Inc., Los Angeles, Calif.

One of the pieces of equipment is The Dallons Cardioscope. It is connected to a patient undergoing surgery. The condition of the patient's heart is visible to the surgeon and anesthesiologist by interpreting a lined pattern made on the scope by the heart's electrical activity. The cardioscope warns the surgeon of impending cardiac difficulty. In addition, the cardiophone attached to the top of the cardioscope gives an audible warning if cardiac difficulty develops. The Dallons Defibrillator can be used in the event of an emergency to stop fibrillation, a frequent fatal rhythm of the heart, and the Pacemaker to stimulate the heart action with an electrical impulse.

This new equipment has a direct relationship to and complements Ohio Chemical's present line of anesthetic gases, anesthesia machines, therapy oxygen, resuscitators and sutures, all of which are used in surgeries.

For descriptive literature, please write Ohio Chemical Canada Limited, 180 Duke St., Toronto, Ontario.

Pamphlets Available

Canadian Laboratory Supplies Limited have available two new pamphlets which they feel will be of interest to hospitals. They are titled, "A Simple Electrometric Technique for the Determination of Carbon Dioxide Tension in Blood and Plasma, Total Content of Carbon Dioxide in Plasma, and Bicarbonate Content in 'Separated' Plasma at a Fixed Carbon Dioxide Tension (40 mm Hg)" and "Apparatus for Anaerobic Determination of the pH of Blood at 38 Degrees Centigrade."

Readers may obtain these free by writing the company offices in Montreal, Toronto, Winnipeg or Edmonton.

Dividers For Medical Records

A means of separating the successive hospital charts of a readmitted patient has just been made available by Physicians' Record

Company, publishers of medical and hospital record forms.

These chart dividers are used for tabbing and indexing the charts of the various admissions of a patient so that the record of each admission may be identified at a glance. The dividers are suitable for use with either the unit system or the serial-unit system of numbering. The most recent admission is always at the front—another way of saving time for the busy medical record librarian or physician.

For sample and additional information, write to Physicians' Record Company, 161 West Harrison Street, Chicago 5, Illinois.

Bard-Parker Sterile Blade Package



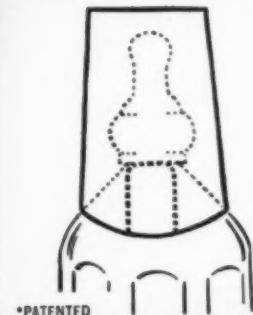
Bard-Parker Company of Danbury, Connecticut have announced the availability of their new sterile blade package. The unit consists of a sterile B-P rib-back blade of carbon steel, heat-sealed in a moisture proof and puncture resistant envelope that can be autoclaved. The easily opened reinforced envelope permits the nurse to attach the knife handle to the blade while in the opened package. B-P sterile packaged blades are available in all sizes in one gross boxes.

Two men sat in the blood bank of a town in Arizona, U.S.A. One was a tourist, the other an Apache Indian.

The tourist stared curiously, then leaning forward, asked: "Are you a full-blooded Indian?"

The Apache thought deeply, then said: "Well, no, I'm about a pint short."—Health.

Remember...



*PATENTED

NipGard
TRADE MARK

DISPOSABLE NIPPLE COVERS . . .

provide space for identification and formula data . . . instantly applied to nipple; save nurses time...cover both nipple and bottleneck. Do not jar off. No breakage. Use No. 2 NipGard for narrow neck bottle . . . use No. H-50 NipGard for wide mouth (Hygiene type) bottle. Be sure to specify type desired.

THE QUICAP COMPANY, Inc.
110 N. Markley St. Dept C
Greenville, South Carolina



Your hospital supply dealer has NipGards. Professional samples on request.

Improve your tray service and save time, work and money too, with Wood's attractive crisp-white tray covers.

Always available—separate easily—there is a size for every standard tray. Dietitians, nurses and patients will all like the eye-appeal of Wood's Tray Covers.

*We will send samples promptly if you will advise us sizes of your trays. Also available, paper food containers, lace and linenized doilies, drinking cups, butter pat dishes, serviettes, etc.

CREATIVE *Art on Paper* DIVISION

G. H. WOOD & COMPANY, LIMITED
TORONTO MONTREAL VANCOUVER
Branches Across Canada

for quick, dependable protection to nursing bottles . . . use the original NipGard* covers. Exclusive patented tab construction fastens cover securely to bottle • For High Pressure (autoclaving) . . . for Low Pressure (flowing steam).

LALONDE presents

a NEW line of FLOOR MACHINES!

Automatic, SELF-PROPELLED, Combination

SCRUBBER and MOPPER

with Self-Winding Reel.

Recommended for Hospitals, Restaurants, Institutions, Hotels, Public and Industrial Buildings, etc., etc.



An extremely powerful machine which does the entire job at once—drops clean water on the floor, scrubs the floor clean, then (by vacuum) picks up the dirty water. When the 'dirty water' tank is full, the water suction stops automatically.

The entire job can be done by one man in less time than it would take three men to do it by the old fashioned hand methods. Not only does it save its cost in labour but it does a much better job.

With all these superb features the cost is very low. Smaller buildings that have hitherto considered such a machine too expensive for their purpose, can now have the convenience, efficiency and economy of such a machine.

Sold and Serviced by local Jobbers from Coast to Coast

We also manufacture 6 different designs of Floor Machines with 23 different sizes (9" to 32") to meet all maintenance requirements. Write for information details.

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...add eye appeal
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require that every article of linen—whether bed linen, towels, or the uniforms and other wearables of doctors and nurses are marked.

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O.R. APPAREL AND ACCESSORIES



SURGEON'S OPERATING GOWN

A full length gown with plain front, standing collar and full length sleeves. Closes down the back with tie tapes, and with long belt stitched on front, to tie at back. Can be furnished with knitted cuffs which fit closely and easily into the rubber gloves. Available in three sizes: small, medium and large.

Style No. 431. Stocked

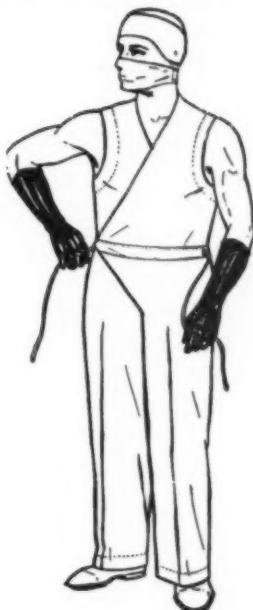
Garments and Accessories
in Color, White or
Unbleached

Quotations and
Catalogue on request

CROSS-TOP OPERATING SUIT

Another one-piece suit requiring no buttons. Featuring cross top, this garment can be easily slipped on without further adjustment. Can be made in bleached, unbleached, or colour.

Style No. 360. Made to order



STYLE NO 356

This one-piece garment (no buttons required) is in great demand for surgeons' work. The adjustable tie tape belt and one piece features alone commend its use. Made from best quality bleached suiting.

Stocked in even sizes 34-44



SURGEON'S BONE GOWN

Similar to our style 431 with the addition of a flap which covers tie opening at the back and is held by all-around belt. This feature makes gown more sterile. Can be made in color, bleached or unbleached materials.



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● **SHOE COVERS, etc.**

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have CLEAN paper towels always handy!



So efficient — They eliminate line up or waiting for someone to finish drying. Economical dispensers can be located wherever convenient.

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So soft — Brompton individual paper towels provide a fast . . . smooth . . . economical drying medium.

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